

**PERCEPTIONS OF YOUNG INDIAN ADOLESCENTS IN CHATSWORTH, TOWARDS
HIV AND AIDS**

by

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DEDICATION

I dedicate this study to my family and friends who have motivated me throughout my research journey.

DECLARATION

Student number: 40872351

DECLARATION

I declare that **PERCEPTIONS OF YOUNG INDIAN ADOLESCENTS IN CHATSWORTH, TOWARD HIV AND AIDS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature: Dhender
Dhanasagree Govender

Date: 14 July 2016

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All my thanks to **my Lord and Saviour Jesus Christ** for wisdom, knowledge and understanding during my studies

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
HIV	Human Immunodeficiency Virus
HSRC	Human Science and Research Council
IPA	Interpretative Phenomenological Analysis
KZN	KwaZulu Natal
MDG	Millennium Development Goals
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
StatsSA	Statistics South Africa
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Fund
WHO	World Health Organization

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ABSTRACT

Aim: The aim of this study was to explore the perceptions' of young Indian adolescents in Chatsworth, towards HIV and AIDS.

Methods: An interpretative phenomenological analysis design was used. The participants were selected using judgemental purposive sampling. Nine participants were interviewed. The sample size was determined by data saturation. Data was collected through individual interviews guided by an interview schedule. The interpretative phenomenological analysis framework for data analysis was used for data analysis.

Results: The study revealed that participants were well informed about HIV and AIDS. Participants reported disinterest in HIV prevention programmes due to inundation with repetitive information; disinterested attitudes of facilitators of these programme as well as fear of social stigmatisation. The misconceptions that were highlighted were related to very little personal contact with people living with HIV and AIDS.

Conclusions and Recommendations: These findings have revealed that there is a need for a revision in HIV/AIDS prevention programme. The HIV/AIDS school programmes should be contextual relevant to learners from diverse backgrounds and communities.

Key Concepts: Adolescents, AIDS, HIV, Indian, Perception

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This study was conducted to explore the perceptions of young Indian adolescents in Chatsworth towards HIV and AIDS. This chapter provides a background to the study, including a problem statement, purpose and objectives of the study. The chapter also offers an overview of the significance of the study, research questions, definitions of key concepts used in the study. Included in this chapter are also brief discussions of research design and method employed in the study, and the layout or organisation of the entire dissertation.

1.2 BACKGROUND TO THE PROBLEM

According to the United Nations Program on HIV/AIDS [UNAIDS] GAP Report (2014:41) Sub-Saharan Africa remains the region most affected by Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). About 70% of new HIV infections in 2010 have occurred in this geographical area; southern African countries continue to be most severely affected by the HIV/AIDS pandemic in sub-Saharan Africa (UNAIDS GAP Report 2014:41). Females have been reported to have a higher infection rate than males; this difference can be attributed to levels of HIV knowledge being lower in females (26%) than in males (35%) (UNAIDS GAP Report 2014:41). Although the adolescent males aged 15-24 years demonstrated higher levels of knowledge regarding HIV/AIDS as compared to females of the same age group, statistics are still shockingly low despite efforts by United Nations International Children's Fund (UNICEF) to promote HIV knowledge (UNAIDS GAP Report 2014:41). Low level of information amongst female adolescents is not only common in South Africa. A study by Mwamwenda (2015:14) revealed that African American adolescents also had low levels of knowledge about HIV and AIDS due to high attrition rates at high schools. Thus it can be stated that low levels of HIV and AIDS information may be the contributing factor to engagement of youth in high risk sexual behaviour.

A study in Ethiopia indicated that young adults, including college students were at high risk of contracting HIV due to their risky sexual practices (Cherie & Berhane 2012:1). A comparative study done by Mwamwenda (2015:14) between American and African adolescents revealed that although American participants who had high levels of knowledge still engaged in risky sexual practices due to low risk perception.

High risk sexual behaviour is one of the biggest hurdles that the South African health system is currently facing (Laurence 2014:12). The fight against the HIV and AIDS pandemic in South Africa and the bid to curtail high risk sexual behaviours among adolescents is at best a feeble attempt (Shisana, Rehle, Simbayi, Jooste, Zungu, Labadarios, Onoya, et al., 2014:1). The afore-mentioned survey revealed a drastic decrease in condom use among adolescent males; from 85.2% in 2008 to 67.5% in 2012. Knowledge of HIV among adolescents has decreased with a concurrent increase in high risk sexual behaviours among adolescent females aged 15-19 years. Many of these young females engaged in sexual activity with older men who are considered as “sugar daddies”, for financial gain due to the abject poverty within which they live (Shefer, Clowes & Vergnani 2012:435; Shisana et al., 2014:1). This may explain the high HIV infection rates in South Africa among adolescents and young adults aged 15-25 years as documented by Shisana et al., (2014:1). The high rate of HIV among this age group implies that attention should be focused on how to reduce the spread of HIV infection amongst the country’s youth (Howard-Payne 2010:106). A comparative study by

A study conducted by Zuma, Setswe, Ketye, Mzolo, Rehle and Mbelle (2010:47) cited age at sexual debut as an important determining factor for safe sexual practices; this study also reported that 39% of participants had admitted to having first sexual encounters before the age of 16 years. The study also stated that condoms are less likely to be used at sexual debut. HIV prevalence among South African Indians is 0.08% (Statistics South Africa 2014:4). Although these statistics are relatively low it does not justify complacency as there are no reliable estimates of young Indian adolescents living with HIV and AIDS in South Africa. Shisana et al., (2014: xxxviii) also stated that 75% of Indians believed that they were not at risk of contracting HIV. This high

percentage is worrying as a sense of exclusivity may predispose to high risk sexual behaviours.

The reasons given for holding this belief were faithfulness to one partner, trust in that partner, abstaining from sex and using condoms (Shisana et al., 2014: xxxviii); however these reasons were generalised to all participants of all race groups who specified that they felt that they were at low risk of contracting HIV and not specific to the Indian population only. The 2012 survey results indicated that whites (43.3%) and Indians/Asians (41.4%) were more knowledgeable about HIV transmission and prevention than their black African and Coloured counterparts (Shisana et al., 2014: xxxviii). Although the rate of infection by race shows that Indians have a low HIV prevalence rate, these statistics may drastically increase if misconceptions prevail.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Although there are several studies conducted regarding perceptions of youth regarding HIV, there is a dearth of literature focusing specifically on the perceptions of Indian adolescents towards HIV and AIDS. If the information is not available specifically from this target population, it will be difficult to plan HIV and AIDS information and services which are contextual and culturally relevant to the Indian youth. This may result in an increase in HIV infection among this group, thus defeating the Sustainable Development Goals by year 2030 (World Health Organisation [WHO] 2015a:1-3).

1.4 AIM OF THE STUDY

The aim of this study was to explore the perceptions' of young Indian adolescents in Chatsworth towards HIV and AIDS in order to develop contextual relevant recommendations regarding strategies for addressing Indian adolescents on HIV and AIDS issues.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were as follows:

- To explore and describe the perceptions of young Indian adolescents in Chatsworth towards HIV and AIDS

- To make recommendations regarding strategies for addressing Indian adolescents on HIV and AIDS issues.

1.6 SIGNIFICANCE OF THE STUDY

There appears to be a paucity of information pertaining to this particular age and racial group with specific reference to the topic under study. This study will shed light on the perceptions of young Indian adolescents towards HIV and AIDS and thus add to the existing body of knowledge. The recommendations made will assist the educators use culturally relevant information when addressing Indian adolescents on HIV and AIDS issues. The findings will also be used to assist HIV and AIDS programme developers to know the relevant aspects to be considered when addressing young Indian adolescents.

1.7 DEFINITIONS OF KEY CONCEPTS

The following concepts were used to guide the literature search:

1.7.1 Acquired Immune Deficiency Syndrome (AIDS)

A severe immunological disorder caused by the retrovirus HIV, resulting in cell-mediated immune response that is manifested by an increased susceptibility to opportunistic infections and to certain rare cancers, especially Kaposi's sarcoma (WHO 2015:1).

1.7.2 Adolescent

A person in the period between childhood and adulthood, who has reached puberty but has not fully matured; from ages 10-19 years (Berman & Snyder 2012:238; WHO 2015:1).

1.7.3 Human Immuno-deficiency virus (HIV)

A retrovirus that affects the immune system thus impairing its function. As the infection progresses, the immune system becomes weaker and the affected individual becomes susceptible to opportunistic infections (WHO 2015:1).

1.7.4 Perceptions

The way in which something is regarded, understood or interpreted. The ability to notice or understand something or a particular way of looking at or understanding something (Oxford South African School Dictionary 2010:446).

1.8 RESEARCH DESIGN AND METHODS

The researcher followed a phenomenological design, focusing specifically on an Interpretative Phenomenological Analysis (IPA). Phenomenological studies examine human experiences through the descriptions that are provided by the people involved (Brink, van der Walt & van Rensburg 2012:121). Interpretative Phenomenological Analysis focuses on individual experience and the meanings that such experience has for people. The aim is to arrive at a rich description of individual cases. This design involves the use of semi-structured, individual interviews. The focus of IPA is on the subjective experiences of people's life world (Polit & Beck 2012:497). This design enabled the researcher to gain insight into perceptions of Indian adolescents in the Chatsworth area regarding HIV and AIDS. This study was conducted in Chatsworth. According to Statistics South Africa 2012:1 the 2011 census reported that Chatsworth has an Indian population of approximately one hundred and seventeen thousand nine hundred and ninety nine (117 999); however there was no definitive information on the population size of 18-19 year old Indian adolescents specific to Chatsworth. Nine (9) participants were interviewed. This sample size was determined by data saturation. Data was collected using individual semi-structured interviews guided by an interview schedule. Data analysis was conducted using IPA framework of data analysis. More details regarding research design and methods utilised in this study is provided in chapter three.

1.9 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness refers to a method of establishing or ensuring scientific rigor in a qualitative research without sacrificing relevance (Lincoln & Guba 1985 in Moule & Goodman 2014:188). To ensure trustworthiness, the researcher conformed to the

following criteria: credibility, dependability, confirmability and transferability. Detailed information regarding the criteria and how they were ensured in this study is provided in chapter three.

1.10 ETHICAL CONSIDERATIONS

The actions essential for conducting an ethical research study are protecting the rights of the participants, balancing benefits and risks in a study, obtaining informed consent from the participants and submitting a research proposal for institutional review (Grove, Burns & Gray 2013:159). The researcher has conformed to all the ethical requirements. Detailed information on how ethical principles were followed is described in chapter three.

1.11 SCOPE OF THE STUDY

The scope of this study is to explore the perceptions of young Indian adolescents towards HIV and AIDS. The study was restricted only to adolescents aged 18-19 years who lived in Chatsworth.

1.12 STRUCTURE OF THE DISSERTATION

This dissertation consists of five chapters and sub-sections. A synopsis of each of these chapters is offered here to allow readers to follow and understand discussions on issues presented.

Chapter one gives a general introduction to the study, including the formulation of the problem, the aim and objectives of the study, and definition of the key concepts used in the study. A brief description of the research design and method, ethical aspects and measures to ensure trustworthiness is also provided.

Chapter two focuses on literature reviewed. It highlights literature search strategy, appraisal of identified literature and themes which emerged from literature reviewed.

Chapter three provides in-depth information on the research design and methodology. Description of the study site, sampling method, data collection and analysis, measures to ensure trustworthiness and ethical issues related to the study.

Chapter four presents the results based on major themes, themes and sub-themes that emerged from data analysis.

Chapter five discusses the findings of the study, in relation to existing literature; provides conclusions and limitations of the study. Recommendations are also put forth based on the research findings.

1.13 CONCLUSION

This chapter addresses the background to the research, research design and methodology, ethical considerations, measures to ensure trustworthiness and the significance of the study. The next chapter discusses literature relevant to the topic under study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is on reviewed relevant literature on perceptions of young Indian adolescents towards HIV and AIDS. A literature review is a critical summary of research on a topic of interest, often prepared to put a research problem in context (Polit & Beck 2012:732). It gives the researcher an understanding of the chosen area as well as the limitations and the importance of studying the topic. According to Grove et al., (2013:40), a literature review is conducted to generate an understanding of what is known about a particular situation, phenomenon or problem and to identify the knowledge gaps that exist. According to Polit and Beck (2012:95), literature review of a research study provides context, confirms the need for new research and demonstrate the writer's ownership of the literature.

The information that the researcher finds during the literature search provides a basis for a study. A literature review has to encompass all relevant documented information. The literature search can be done manually and/or electronically (Brink et al., 2012: 54). This "background check" enables researchers to build on the work of others. By reviewing relevant studies, researchers are able to clarify which problems have been investigated; which problems require further investigation and which problems have not been investigated (Grove et al., 2013:40). Literature review also assists the researcher in determining the most appropriate research methodology, including the research instrument to be utilised. This chapter gives a detailed process for literature review covering the aspects of focus question, search strategy, search profile, appraisal of identified studies, and themes and sub-themes that emerged from the literature sources.

2.2 FOCUS QUESTION

Focus question is a statement that offers the precise query a researcher wants to answer with the view of addressing a research problem (Grove et al., 2013:276). To successfully conduct a literature review, a focus question or questions need to be developed to enable the researcher to refine his or her literature search strategy. The

researcher used Kumar's (2005) framework for formulating the focus question of this study. This framework emphasises that questions should be formulated using the four Ps; People, Problem, Programme and Phenomenon. The five Ws (why, what, when, who and where) and How, was also considered in the formulation of the focus question of this literature review (Bryman, Bell, Hirschsohn, DosSantos, Du Toit, Masenge, Van Aardt, & Wagne 2014:205). The following question was formulated: *What are the perceptions of young Indian adolescents towards HIV and AIDS?*

2.3 SEARCH STRATEGY

To ensure that the literature review explored the subject holistically, a systematic approach was used to search available databases. The University of South Africa's (UNISA) electronic data bases were used. Examples of the databases searched were SAGE, EBESCO, Google Scholar and Research gate. The Stellenbosch University's research repository, SUNScholar, was also used as well as websites of reputable research organisations such as the Human Science and Research Council (HSRC), Statistics South Africa (StatsSA), the World Health Organization (WHO) and the Kaiser Family Foundation, among others. The following words were used as search terms: adolescents, AIDS, HIV, perception and adolescents. Each of the search terms were initially used individually, and then combined using Boolean operators "and" and "or".

Due to the paucity of information specific to the South African Indian community as well as Indian adolescents and HIV the researcher broadened the scope of the literature review by including literature pertaining to all race groups. The inclusion and exclusion criteria outlined below were used to guide the literature review process:

2.3.1 Inclusion criteria

- Studies that focused on the determinants of risky sexual behaviour among adolescents.
- Studies that focus on knowledge of HIV and AIDS among adolescents in the global, sub-Saharan and South African contexts.
- Studies published in English.

- Only literature from validated and accredited academic databases and websites.
- Studies that focus on addressing the spread of HIV/AIDS and risky sexual behaviour.
- Studies not older than 5 years.

2.3.2 Exclusion criteria

- Studies whose academic credibility could not be verified.
- Studies not written in English.
- Studies older than five years
- Studies that did not focus on the determinants of risky sexual behaviour among adolescents.
- Studies that did not focus on knowledge of HIV and AIDS among adolescents in the global, sub-Saharan African and South African contexts.

2.4 APPRAISAL OF IDENTIFIED STUDIES

Only 26 articles met the criteria for inclusion in the study. The process of reviewing each study was based on guidelines offered by Grove et al., (2013:462-464). According to Grove et al., (2013:462) three pre-requisites are needed when appraising qualitative studies viz. an appreciation for the philosophical foundation of qualitative research; knowledge of different qualitative research and empathy for the participant's perspective. The review of the studies was weighted on the knowledge contribution made to current understanding of how adolescents perceive HIV and AIDS. The studies were evaluated in terms of credibility, dependability, transferability and confirmability. Several themes emerged during this literature review.

The following were the stages of appraising the research articles used in this study:

Stage 1: Reading and re-reading the articles

Stage 2: Initial note making

Stage 3: Development of emergent themes: looking for themes

Stage 4: Searching for connections across the emergent themes

Stage 5: Development of final themes

Five major themes emerged during the literature review process, and the emergent themes served an important role in supporting the discussions of the findings of this study.

2.5 EMERGENT THEMES

The following themes emerged from the literature sources reviewed:

- Knowledge of HIV and AIDS among adolescents
- Myths and misconceptions
- Sources of HIV and AIDS knowledge
- Adolescent high risk behaviours
- Risk perception
- Stigmatisation

2.5.1 Knowledge of HIV and AIDS

Knowledge of HIV is important for prevention of HIV among adolescents. The National Adolescent Sexual and Reproductive Health and Rights Framework strategy 2014-2019 (Department of Social development 2015:1) emphasises sexual and reproductive health as a universal right for every individual. This right includes empowering individuals with relevant information and healthcare services to enable individual to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition that these decisions do not infringe on the rights of others.

Farahani, Shah, Cleland and Mohammadi (2012:101-110) and Srivasta, Mahmood, Mishra, Shrotriya and Shaifali (2011:87) reported that in Iran and India reproductive health can be integrated into the school syllabus but not sex education. Inclusion of sex education is a cultural taboo. The view of sex education as a taboo is enforced by public and religious outcry to stop most schools especially in rural areas from teaching these subjects. Schools are burnt and teachers are assaulted in those schools that teach sex education (Farahani et al., 2012:103; Srivasta et al., 2011:87). This has resulted in high

incidences of new infections as the adolescents are not getting correct information about how the infection is spread. Many of the female adolescents interviewed verbalised that they would like to attend school the same as their urban counterparts but lack of money and marriage has prevented that from happening (Farahani et al., 2012:103; Srivasta et al., 2011:87).

In India where child brides are a common practice, families don't send their girl child to school as they view it as a waste of money as the girl is already married. In Iran and rural India cultural taboos about sex and sex education; especially to young females, played a major role in prohibiting the dissemination of information with any content pertaining to sexual behaviours (Srivasta et al., 2011:87).

Adolescents in the United States of America were more knowledgeable of sex information than their counterparts in Iraq and India (Geevers, Jewkes, Mathews & Fisher 2012:1131). This is because in the United States of America, information about reproductive health and sex education is freely disseminated in high schools and in the media (Geevers et al., 2012:1131). However due to high attrition rates at schools, especially amongst minority populations such as African Americans and Latinos in the United States, many adolescent do not receive the information as they are not in the schooling system or due to their low risk perception towards HIV and AIDS (Geevers et al., 2012:1132). The same also highlights that white Americans were more informed about information about reproductive health and sex education than their black counterparts (Geevers et al., 2012:1132). A similar study done in America by Murray, Huang, Hardnett and Sutton (2011:34) amongst African American adolescents aged 14-24 years revealed that general HIV knowledge such as mode of spread, importance of condom usage was high. However these same participants were not aware that using alcohol and/or drugs before sexual activity increased a person's risk of getting HIV. It can thus be said that knowledge on its own is not enough to reduce engagement into sexual risky behaviour but also risk perception.

To ensure that learners in South Africa have information regarding HIV and AIDS, Life Orientation was introduced as a school subject in 1998 by the Department of Education

(Jacobs 2011:212). The purpose of Life Orientation was to provide age relevant information to school learners regarding sexual and reproductive health in an attempt to curb the increase in the HIV prevalence and teenage pregnancies (Jacobs 2011:215).

Despite Life Orientation as a subject, the HIV prevalence among young adolescents had risen from 240 000 in 2006 to 370 000 in 2013 (United Nations Program on HIV/AIDS [UNAIDS] 2013:5). In Kwa Zulu-Natal (KZN) the prevalence of HIV among young people aged 15-24 years is among the highest in the country (Harrison, Newell, Imrie & Haddinott 2010:102; Shisana et al., 2014:42).

A survey carried out in 2012 in South Africa reported that whites and Indians were more knowledgeable about sexual transmission of HIV than their black and Coloured counterparts (Shisana et al., 2014:74). The same study also reported that black Africans living in urban areas were more knowledgeable than those living in rural areas. Knowledge deficit among rural black Africans can be attributed to poor infrastructure such as poor or no schooling facilities, poorly trained teachers, high number of students and lack of resources. Electricity is still not supplied to the majority of the rural population as well poor socio-economic circumstances do not allow for money for schooling.

Cultural taboos also prevent older women from educating the younger girls about sexuality and reproduction or they themselves perpetuate misconceptions due to their own lack of knowledge (Shisana et al., 2014:78). Aspects of cultural taboo regarding sex education were also reported in several studies (Farahani et al., 2012:103; Srivasta et al., 2011:87).

Besides variations in levels of HIV information among diverse adolescents based on culture, race and location, literature reviewed also indicated that there are several misconceptions and myths related to HIV and AIDS.

2.5.2 Misconceptions and myths

Despite the abundance of information on HIV and AIDS being readily available, international studies reviewed revealed that many misconceptions and myths prevailed.

A study carried out by Srivasta et al., (2011:87) and Verma, Nandan and Shrotriya (2014:23) in India revealed that most of the participants believed that HIV could be spread through mosquito bites, by sharing meals with HIV infected people and by sharing public toilets. There was also a prevailing belief that HIV could be cured with the correct treatment. This belief was not noted in the other studies that were reviewed.

There is still a large number of Haitians who subscribe to traditional voodoo beliefs i.e. disease is caused by the supernatural therefore only the supernatural can cure the disease not modern medicine (Devieux et al., 2014:2019). This has led to non-compliance to seeking HIV testing; not using prescribed antiretroviral drugs and a lack of lifestyle modification such as decreasing high risk behaviour (Devieux et al., 2014:218). Another common thread is the relationship between the number of sexual partners and virility.

Oladebo and Fayemi (2011:31) identified many myths among Nigerian youth; the most common ones being that sexual intercourse is a normal practice and that young people cannot live without sex; if a male does not have sex by age 16 years, it means that he is impotent and this will result in 'stomach problems' and he may have a low sperm count as well as he will not have the skills to satisfy his future sexual partners; if a female does not have sex by age 19 years, her vagina may close up and when she does want to have sex later, it will be painful; it is also believed that prolonged sexual abstinence may cause infertility and leads to the female having a Caesarean section during childbirth. Other common misconceptions among Nigerian youth were that HIV could be contracted from using the same toilet seat used by a person who is HIV positive; HIV is God's way to punish sinners; AIDS can be cured by having unprotected sex with a virgin and that HIV and AIDS is caused by witchcraft (Muthivi, Sodi, Maunganidze & Mudhovozi 2011:586).

A religious connotation to the HIV and AIDS epidemic appears to be a common thread in sub-Saharan Africa and in the Caribbean. A continuing belief in the power of the supernatural to cause disease has weakened the effects of interventions designed to reduce the spread of HIV in the Caribbean (Devieux, Rosenberg, Saint-Jean, Bryant & Malow 2014:217).

Conspiracy theories amongst South African youth related to people being used as 'guinea pigs' were also commonly endorsed by many black male participants. They believed that people were being experimented on with new HIV treatments in South Africa without their knowledge. They also believed that researchers use black people as 'lab rats' in HIV research studies. These conspiracy beliefs led to decreased compliance to antiretroviral medication and HIV testing (Tun, Kellerman, Mcumane, Fipaza, Sheehy, Vu & Nel 2012:462-463). Myths and misconceptions related to HIV and AIDS may be linked to sources of information.

2.5.3 Sources of information

Adolescents receive information related to HIV and AIDS and also sex education from several sources. According to Muthivi et al., (2011:586) and Shisana et al., (2014:98), radio and television were found to be the main sources of information when it came to media and technology. The internet, magazines and magazines were found to be less popular as sources of HIV and AIDS information (Muthivi et al., 2011:586; Shisana et al., 2014:98). The reason for this can be due to the fact that the current generation of adolescents do not read as much as previous generations. The implication is that government driven initiatives such as Life Skills and Life Orientation that were introduced into schools as part of the curriculum do not seem to have the same impact when compared to programmes such as LoveLife and Soul City (Muthivi et al., 2011:586). Studies further revealed that exposure to HIV related information via television and /or radio showed an increase in knowledge of modes of HIV transmission followed by an increase in condom use (Peltzer, Parker, Mabaso, Makonko, Zuma & Ramlagan 2012:1).

In many cases the primary source of information for adolescent girls regarding sexual matters was their friends who played a pivotal role in providing inadequate and incorrect information (Mosavi, Babazadeh, Nagmabadi & Shariati 2014:112). Many of these friends were equally inexperienced in relationship issues. The main reason for adolescents turning to each other for information is because they feel more comfortable discussing these issues amongst themselves than with their parents or other adults. The girls were afraid that if they sought information from adults it may be misconstrued that they were sexually active which could result in negative sanctions from adults. (Geevers et al., 2012:1130). However in conservative societies such as India, adolescents have great difficulty in obtaining information or accessing health services pertaining to reproductive health as discussions about these issues are still taboo in Indian society; neither the media nor schools are allowed to propagate this information (Srivastava et al., 2011:86; Verma et al., 2014:23).

2.5.4 Adolescent high risk behaviours

Youth is regarded as a period during which people explore and discover a range of life events or behaviours, such as early onset of sexual intercourse (Liao, Jiang, Yang, Zeng & Liao 2010:45). Youth often get exposed to or engage in sexual risk behaviours, like unprotected sexual intercourse and multiple sexual partners.

A situational analysis of adolescent sexual and reproductive health identified the following major trends and concerns: higher levels of sexual activity amongst young male adolescents, significant percentages of sexually active adolescents below the age of 16, increasing trends of multiple concurrent sexual relations, increasing trends of inter-generational sexual relations, high level of substance use and abuse (i.e. alcohol and drugs) especially amongst males especially prior to sexual activity, increased uptake of condom usage but low levels of consistent condom usage during sex, high levels of HIV and AIDS among young people, increased levels of sexually transmitted infections(STI) treatment amongst female adolescents. These factors will be discussed further:

2.5.4.1 *Early sexual debut*

Starting sexual activity at an early age increases lifetime risk of acquiring HIV and is linked with other HIV risk factors such as alcohol use and the use of other mind altering substances, unprotected sex, unplanned pregnancy and multiple sexual partners. Educating adolescents on delaying sexual debut is an important preventative measure for HIV (Shisana et al., 2014:4).

In a study done in South Africa by Shisana et al., (2014: xxxi) majority of the participants aged 15-24 years reported having had sex for the first time before the age of 15 years. The findings from this study were similar to the findings in a study of adolescents, aged 15-17 years, in Cape Town. In the Cape Town study boys reported sex as a goal of engaging in intimate relationships and described several strategies to achieve this goal; including 'sweet talking' the girl, getting girls drunk, organising opportunities to be alone with a partner or initiating sexual behaviour. These boys also stated that peers helped them to devise plans to have sex such as by arranging a private location. In this study the older girls disclosed that they wanted to have sex with their boyfriends whilst the younger girls indicated that they did not want to have sex but felt pressured to have a boyfriend and become sexually active. There was also little agreement amongst the participants about who in the relationship was responsible for contraception (Geevers et al., 2012:1130-1131).

2.5.4.2 *Age disparate relationships*

Age disparate relationships are relationships in which the age gap between the sexual partners is five years or more (UNAIDS Terminology Guidelines 2015:12). The driving force behind the age-sex disparity in HIV infections is the high prevalence of intergenerational relationships between young women and older men (Shisana et al., 2014:60).

A study in Malawi by MacPherson, Sadalaki, Njoloma, Nyongopa, Nkhwazi and Mwapasa (2012:7) reported that young girls felt flattered by the attention of older men, and many relationships were built on the basis of love; however in other instances the key factor for the young girl was financial or social benefits, commonly known as transactional sex. A key motivation for young women engaging in these exchanges was economic vulnerability.

A South African study by Dellar, Dlamini and Abdool Karim (2015:66) indicated that a young girl engaging in a sexual relationship with an older man is at much higher risk of acquiring HIV compared to a young girl engaging in a sexual relationship with a male peer. This study also stated that the reason that adolescent girls are so vulnerable to HIV infection is due to the power- gender dynamics that are prevalent in the South African setting whereby a young girl engaging in a sexual relationship with an older man may be less likely to insist on condom use (Dellar et al., 2015:66).

2.5.4.3 *Multiple sexual partners*

One of the major risk factors for HIV infection in South Africa is having multiple sexual partners. Having multiple sexual partners increases the risk of exposure to HIV through expanding sexual networks. During the acute phase of HIV infection the viral load is high, increasing the risk of transmission (Shisana et al., 69:5).

In a study by Zuma et al., (2010:47) it was stated that multiple sexual partners are more common among those that have early sexual debut. In the same study male participants, aged 15-19 years, reported that they had concurrent multiple sexual partners (Zuma et al., 2010:51). It was also reported that youth with secondary or less educational level were more likely to have multiple sexual partners than those with higher levels of education (Zuma et al., 2010:52). Similar results were reported in a study by Gevers et al., (2012:1130) where male participants of the same age group indicated that they preferred casual relationships to serious relationships. Many of them reported casual sexual encounters with strangers while they were in an intimate

relationship with someone else. Male participants preferred these casual relationships as they were not interested in love because they were too young to settle down.

2.5.4.4 *Inconsistent condom use*

Condoms when used correctly and consistently are an effective means to prevent HIV infection. Despite this being a major strategy by government to promote safer sex, condom use by youth at last sexual encounter has decreased (Shisana et al., 2014:127).

Ritchwood, Penn, DiClemente, Rose and Sales' (2014:543) study revealed that African-American adolescent females reported low levels of condom use; less than half used a condom at last sexual intercourse; most reported a high number of sexual partners. Consistent with previous studies, age disparity between sexual partners played a major role in determining condom use. Female youth with male partners closer to their age had more consistent use of condoms whereas females with an older partner reported inconsistent condom use. This affirms previous studies that in an age disparate relationship the man has more dominance.

A similar study by Guan, Coles, Samp, Sales, DiClemente and Monahan (2016:20) conducted among African-American adolescents confirms the assertion that many young women are afraid to negotiate condom use as they are financially and socially dependent on their older male partner ; therefore maintaining the current relationship outweighs forcing the issue of wearing a condom during sexual intercourse. These women also reported fear of rejection and/or threats and abuse when the topic of condom use was raised.

From a South African perspective men younger than 23 years of age did not generally test for HIV but used condoms more often as compared to their older counterparts (Mhlongo, Dietrich, Otjombe, Robertson, Coates & Gray 2013:5). Being unaware of one's HIV status may be a motivating factor in condom use. However, despite younger men being more compliant to condom use, condom use was not consistent and with a lack of HIV testing they put their partners at risk of HIV infection as the study also

reported that the participants had reported multiple sexual partners (Mhlongo et al., 2013:5). The finding that older men are less likely to use condoms affirms previous studies that older men in age disparate relationships refuse to use condoms and therefore put their young partners at risk of HIV infection. Similarly, a study of South African secondary school youth reported that most of those that had sex within six weeks of the study had reported condom use but not consistently prior to that; however a third of the male participants reported having never used a condom during vaginal penetration (Devine-Wright, Abraham, Onya, Ramatsea, Themane & Aarø 2015:680).

2.5.5 Factors contributing youth to be engaged in risky sexual behaviours

There are several factors which contribute to engagement of adolescents into risky sexual behaviours. The factors include socio-economic status, cultural issues and peer influences (Devieux et al., 2015:217). These factors will be discussed further in the following section.

2.5.5.1 *Socio-economic factors*

The existing practice of young girls having sexual practices with men at least 10 years or more older than them is a common phenomenon in poverty stricken countries like Haiti (Devieux et al., 2014:218) and South Africa (Bhana & Pattman 2011:962). Financial hardships have contributed to early sexual debut and the use of sex as a means of obtaining food, clothing and shelter; this practice is also seen among young boys as well; they engage in sexual relations with older women (Woods-Jaeger, Sparks, Turner, Griffith, Jackson & Lightfoot 2013:1541). Economic factors played a major role in the decision of whether to engage in premarital sex or not; female adolescents who were financially dependent on older romantic partners were afraid to say no to premarital sex as this may result in the partner leaving them and thus the source of income is lost (Oladepo et al., 2011:31). Poverty is not the only reason for this form of transactional sex, consumerism plays a major role. A study done by Bhana et al., in 2011 with a group of adolescent girls found that love and aspirations for a better socio-economic status were inextricably linked in the minds of these young women; they

engaged in sexual activities with older men for designer clothing, jewellery and apartments in upmarket areas. Statelessness such as migrancy also compels migrant adolescents to engage in risky sexual behaviours with older man for financial security (Mavhandu-Mudzusi, Sandy & Shabangu 2014:2876).

A little known South African phenomenon is the 'taxi queen.' These are young adolescent girls who travel with older taxi drivers and have sex with them for money and/or gifts. For the taxi driver having his 'queen' at his side boosts his masculinity among his generational peers and is also a statement of his sexual prowess (Bhana et al., 2011:963). Socio-economic factors also influence condom use. According to the UNAIDS GAP Report (2014:56) adolescents aged 13-15 years do not use a condom during sexual intercourse due to lack of affordability.

Religious attachment, parental control, and level of parental education are some examples of social factors that may influence youths to engage in sexual risk behaviours (Mavhandu-Mudzusi, Sandy & Gamtie 2016: 578).

2.5.5.2 *Cultural norms and values*

A common cultural belief in countries such as Haiti (Devieux et al., 2014:218) and South Africa (De Vries, Eggers, Jinabhai, Meyer-Weitz, Sathiparsad & Taylor 2014:1087) is that it is acceptable for young boys to become sexually active at a young age as well as to have multiple sexual partners; this is seen as a sign of masculinity. In the same study by de Vries et al., (2014:1087) a social problem that is common in South Africa among the Black population was identified- forced sex. Forced sex was seen as an expression of masculinity and that it is such masculinity that women desire; a 'real man' is expected to be in control of his woman and violence may be used to establish this control; this was not seen as rape by either the male or female partner (De Vries et al., 2014:1087-1088). The male partner did not use a condom as a sign that he was the 'master' of the relationship; females expressed the belief that silence and submission was the appropriate response as forced sex was an expression of love and infidelity may not be liked but had to be tolerated (De Vries et al., 2014:1095). The same study recorded that

forced sex was seen as a sign of love, an appropriate way to satisfy sexual urges and as acceptable if the girl was financially dependent on the boy; it was also seen as an effective way to punish a female partner, especially if she had rejected his declaration of love. This display of sexual prowess would change her mind.

2.5.5.3 *Peer Influences*

Peers influence behaviour and the need to be accepted or fit in dominates as it is an everyday reality (Thippeswamy & Gorvine 2012:85). This statement by Thippeswamy et al., was confirmed in a study done by Frederick, Wilkins, Russon and Kirkpatrick-Harrison (2014:10) in the Caribbean that revealed that adolescents aged 11-16 years of age were engaging in high risk behaviours such as drug use and alcohol consumption because their friends were doing it and they did not want to be left out of the popular groups. Similar results were found among Russian adolescents in a study by Abdala, Hansen, Toussova, Krisnoselskikh, Kozlov and Heimer (2012:1598). Alcohol use has also been linked to risky sexual behaviours such as unprotected sex and high rates of partner change (Abdala et al., 2012:1599).

A study by Oladepo et al., (2011:31) reported that male adolescents in the 15-19 year age group engaged in premarital sex due to peer pressure and the need to conform; one participant stated that if boys don't "sleep around" then their masculinity is questioned and they are not accepted into peer groups.

2.5.6 Risk Perception

Teenagers often view themselves as invincible, yet they are the most severely affected by the HIV epidemic. Many studies have shown that an increasing number of adolescents are of the opinion that they are immune to being infected with HIV. This sense of invulnerability to HIV predisposes them to high risk sexual behaviours as well as increases the likelihood that they will ignore advice for safe sexual practices; thus it can be concluded that high risk perception acts as a trigger for engaging in safer sexual practices.

A comparative study done by Mwamwenda (2015:12) between American and African adolescents revealed that both sets of participants believed that they were invulnerable to becoming HIV positive. Even though knowledge is high among American adolescents risk perception is very low as they believe that this is a disease largely affecting the African continent. The African adolescents, especially the South Africans, had low to non-existent knowledge about HIV and AIDS; with many youth even denying the existence of the disease. African youth who were knowledgeable considered themselves invulnerable to becoming infected. They believed that it was something that happens to others but not to them. It is interesting to note that both American and African adolescents who believed that they were not at risk engaged in high risk sexual behaviours such as multiple partners and inconsistent condom use. This perception of invulnerability is increasing the HIV prevalence rate.

Iranian adolescent girls have a low risk perception despite engaging in high risk behaviours. Due to the need to remain a virgin for their husbands, adolescent girls are engaging in anal sex as they believe that HIV can only be spread through vaginal penetration. They prefer their partners not to use condoms as they believe that their partners are faithful to them because they are faithful to their partners (Farahani et al., 2012:110). This low risk perception due to the faithfulness on the part of the female adolescent in the relationship was also seen among Brazilian teenagers (de Aguiar & Camargo 2014:166).

Despite the high knowledge among Caribbean and South African youth, risk perception among female adolescents is very low. The reason behind this low risk perception is very similar for female adolescents from both countries. Caribbean (Devieux et al., 2015:217) and South African (De Vries et al., 2014:1087) female adolescents who are in long term relationships believe that they will not become infected with the virus because they do not 'sleep around'; however, they cannot confirm if their partners are faithful to them but they trust their partners to take care of them. Condom use also decreases the longer the relationship lasts due to this incorrect perception of faithfulness (de Aguiar & Camargo 2014:166). It can thus be deduced that the higher the risk perception the lower the high risk behaviours will be.

2.5.7 Stigmatisation

The issue of stigma is very important in the fight against the HIV and AIDS epidemic in Africa as it may negatively influence peoples' compliance to HIV testing and/or compliance to antiretrovirals. Not only is society's opinion of importance to people living with HIV and AIDS but also those of healthcare workers at healthcare facilities.

Attitude toward people living with HIV and AIDS and resultant stigmatisation has been reported to be closely associated with HIV prevalence in the area (Abrahams & Jewkes 2012:4). A study by Abrahams and Jewkes (2012:4) in urban and rural Cape Town reported that urban participants viewed HIV as a common occurrence and therefore easy to accept. Many of the participants reported at least one family member who was HIV positive. However, rural participants reported being insulted by close family members viz. parents and siblings. Ostracisation by friends was very common. Females in particular were fearful of being morally judged as being "jollers" (partying with men). Moral judgement was reserved for women only; men expressed no concerns about being labelled as promiscuous. Females were encouraged by family to keep their status a secret (Abrahams & Jewkes 2012:5). Knowledge about HIV has been cited by Abrahams and Jewkes (204:8) as an important factor in determining attitudes toward people living with HIV and AIDS i.e. urban participants reported higher knowledge than rural participants. A similar study by dos Santos, Kruger, Mellors, Wolvaardt and van der Ryst (2014:14) reported that the most severe form of stigmatisation experienced by participants was of ostracisation by friends and family. In both these studies negative attitudes of society have resulted in participants not attending clinics for follow up appointments.

Nurses play a major role in the care of patients with HIV and AIDS and need to be well informed with current knowledge and skills to effectively care for these patients. Attitudes toward these patients will determine the type of care the patient receives as well as will influence whether he will return for follow up care.

A study by Dharmalingum, Poreddi, Gandhi and Chandra (2015:25) in India among undergraduate nursing students reported that these nursing students had a moderate

level of knowledge. They had deficiencies in knowledge and misconceptions about the spread of HIV. These deficiencies had resulted in discriminatory attitudes by some of the student nurses toward patients that had been HIV positive. A similar study done in South Africa by Famoroti, Fernandes and Chima (2013:7) reported above average knowledge about HIV and AIDS but some gaps did exist. Those nurses with gaps in knowledge reported decreased level of care to HIV positive patients as compared to those nurses who did not have gaps in knowledge.

2.6 CONCLUSION

This chapter elaborated the findings from literature in relation to adolescence and HIV and AIDS. Aspects such as information related to HIV/AIDS information, risky sexual behaviours which predisposes adolescents to high risk of HIV Infections and factors contributing to the engagement to such risk are highlighted. However, the findings are focusing on adolescents from other ethnic groups globally and in South Africa and how those adolescents perceive HIV and AIDS. None of the literature focused on young Indian adolescents in Chatsworth. This is a gap which this study addressed. Hence this study which aimed at exploring the perceptions of Indian adolescents in Chatsworth with regard to HIV and AIDS. The next chapter focuses on the methodology and specific design employed to conduct this research study. Ethical issues are also addressed in the next chapter.

CHAPTER 3: RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The previous chapter gave a detailed discussion on relevant literature reviewed regarding perceptions of adolescents with regard to HIV and AIDS. In this chapter the researcher focused on the research approach, research design, sampling techniques, data collection and analysis methods utilised to explore and describe the perceptions of Indian adolescents towards HIV and AIDS. Measures to ensure trustworthiness of the research findings and ethical considerations are also discussed in this chapter.

3.2 RESEARCH APPROACH

The researcher followed a qualitative approach. A qualitative approach allows the researcher to obtain an in-depth description and understanding of peoples' beliefs, experiences and perceptions (Brink et al., 2012:121). Grove et al., (2013:705) defined qualitative research as a systematic, interactive, subjective approach used to describe experiences of participants and the meaning they ascribe to their experiences. Qualitative research is an umbrella term for a number of diverse approaches which seek to understand, by means of exploration, human experiences, perceptions, motivations, intentions and behaviour (Holland & Rees 2010:71). According to Polit and Beck (2012:60), in qualitative studies, the researcher collects primarily qualitative data that is narrative descriptions. Qualitative research is based on a naturalistic paradigm which is based on belief that reality is constructed by the individual, not the researcher (Houser 2012:36). The in-depth probing nature of this approach is useful in exploring a phenomenon which has a paucity of information. As the researcher wanted to have an in-depth and holistic understanding about the perceptions of Indian adolescents, regarding HIV and AIDS, qualitative research enabled the researcher to have such narratives of their perceptions of HIV and AIDS. Qualitative approach was employed in this study in an attempt to fill this gap in existing information. Other methods, such as a quantitative approach would not have provided the researcher with the emotive aspect associated with HIV and AIDS.

In relation to this study, the qualitative approach enabled the researcher to provide rich descriptions of the perceptions of Indian adolescents regarding HIV and AIDS, using nine (9) participants as data sources. The researcher used a semi-structured interview format with the help of an interview schedule instead of a structured questionnaire or interview schedule. This allowed the researcher to know more about the phenomenon under study from the viewpoint of the participants based on their own personal life experiences and world view.

The discussion thus far is consistent with Creswell's (2014:185) view of what constitutes qualitative inquiry. According to Creswell (2014:185) data in quality research are to be collected in "participants" natural setting, and this was the case in this study. The researcher had an opportunity to use interviews and field notes as the two main methods of data collection.

3.3 RESEARCH DESIGN

Grove et al., (2013:195) defines research design as the blueprint for conducting a study. According to Polit and Beck (2012:58) a research design of a study outlines the basic approach that the researcher uses to answer research questions. Langford and Young (2013:86) defined a research design as an overall plan that helps a researcher obtain answers to the research questions and assist researchers to address challenges that may arise during the conduct of research. The researcher followed a phenomenological design, focusing specifically on an Interpretative Phenomenological Analysis (IPA). Phenomenological studies examine human experiences through the descriptions that are provided by the people involved (Brink et al., 2012:121).

The IPA is utilised due to its phenomenological, interpretative, double hermeneutic and idiographic nature (Smith, Flower & Larkin 2009:3). IPA is considered *phenomenological* because it is concerned with an individual's perceptions of lived experience and also how participants perceive an event or object (Griffiths 2009:39; Smith et al 2009:3). *Interpretative* element of IPA is based on its ability to enable the researcher to gain access to and understand an individual's world using interviews and their perceptions. This requires the researcher to be capable of conceptualizing and

making sense of the participant's personal world through interpretative activities (Griffiths 2009:39). *Double hermeneutic* nature of IPA is based on the fact that both the researcher and participants try to make sense of and understand phenomenon studied (Smith et al., 2009:3). The idiographic nature of IPA is based on the fact that the experience of each individual participant is considered as unique case not as compared to all other participants' experiences (Smith et al., 2009:48).

Interpretative Phenomenological Analysis focuses on individual experience and the meanings that such experience has for people. The aim is to arrive at a rich description of individual cases. The design involves the use of semi-structured, one-on-one interviews. The main feature of IPA is its emphasis on phenomenology and interpretation. The focus of IPA is on the subjective experiences of people- their life world (Polit & Beck 2012:497).

The aim of IPA is to explore in detail how participants are making sense of their personal and social world. The main currency for an IPA study is the meanings particular experiences or events hold for participants. IPA is concerned with an individual's personal perception of an event. IPA is a suitable approach when one is trying to find out how individuals perceive the particular situations that they are facing and how they make sense of these experiences (Smith & Osborne 2007:53-54). IPA involves conducting individual interviews with each participant. In this way the researcher gained insight into perceptions of Indian adolescents in the Chatsworth area regarding HIV and AIDS.

3.4 RESEARCH METHODS

3.4.1 Research setting

The setting is the location where the study is conducted. Qualitative studies are often carried out in a natural setting; that is an uncontrolled, real-life environment that is not manipulated or changed by the researcher (Grove et al., 2013:373). The study was conducted in a Chatsworth suburb. Chatsworth is situated within the eThekweni

municipality, of Kwa Zulu-Natal Province. Chatsworth is a large suburb south of Durban, which was created in the 1960s as an Indian Township. It is predominantly occupied by the Indian community. Chatsworth comprises of families with diverse socio-economic, religious, cultural and educational backgrounds (South African History Online 2015).

3.4.2 Population

Population is the entire set of individuals who have common characteristics (Polit & Beck 2014:387). The population of this study included Indian adolescents (18-19 years old) from within the Chatsworth community. The researcher focused on adolescents that lived within the Chatsworth community.

3.4.3 Sampling and sample size

A sample is a subset of the population that is selected for a study (Grove et al., 2013:708). Sampling is a process of selecting a group of people, events behaviours, or other elements that are representative of the population being studied (Grove et al., 2013:709). The researcher used judgemental purposive sampling. Borbasi and Jackson (2012:135) define judgemental purposive sampling as a type of sampling where the units to be observed are selected on the basis of the researcher's judgement about which one will be most representative or yield more required information. Parahoo (2014:44) indicates that this type of sampling involves making a judgement or relying on the judgement of others in selecting a sample. In order to successfully get participants who will be more useful, the researcher needs to set eligibility criteria.

Grove et al., (2013:352) define eligibility criteria or sampling criteria as a list of characteristics essential for membership or eligibility in the target population. Eligibility criteria are divided into inclusion and exclusion criteria. Inclusion sampling criteria has those characteristics that a subject or element must possess to be part of the target population and exclusion criteria is defined as those characteristics that can cause a person or element to be excluded from the target population (Grove et al., 2013:353). For this study, the following eligibility criteria were set based on inclusion and exclusion criteria:

Inclusion criteria

- Adolescents who are Indians as the study is about the perceptions of Indian adolescents.
- Adolescents aged 18-19 years as they do not need parental consent to participate in the study.
- Adolescents who have lived in the Chatsworth area since they were 10 years old as they will be able to share their perceptions regarding HIV from that early adolescent stage to their current stage .
- Able to understand and speak English as the use of an interpreter may make it difficult to properly adhere to the elements of Interpretative Phenomenological analysis design such as interpretative, double hermeneutic and idiographic.

Exclusion criteria

- Adolescents who are non-Indians
- Adolescents younger than 18 years of age and older than 19 years.
- Adolescents who have started living in Chatsworth while they are older than 10 years of age.
- Not able to understand and speak English

For initial recruitment of the participants using judgemental purposive sampling, the researcher was dependant on her own judgement.

The researcher approached and requested two participants who met inclusion criteria. The researcher observed that the initial two participants were not comfortable with the subject under study as they were familiar with the researcher and this would most likely lead to the participants providing information that they thought would be appropriate instead of their own perceptions. To prevent this from happening, the researcher resorted to snowballing technique which according to Parahoo (2014:44), is relying on the judgement of others in selecting a sample. Snowball sampling involves the assistance of study participants in obtaining other potential participants, especially where it is difficult for the researcher to gain access to the population (Brink et al.,

2012:142). This was done through requesting the two identified participants to refer the researcher to their peers who meet the inclusion criteria. The identified participants were contacted telephonically and the relevant information was given to them.

For those participants who agreed to participate an appointment was made with them to obtain permission and thereafter to conduct the interview. The researcher intended to interview 12 participants but data saturation and redundancy of information was reached by participant nine (9). According to Grove et al., (2013:691) data saturation in qualitative research occurs when additional sampling provides no new information, only redundancy of previously collected data.

3.4.4 Data Collection

Data collection is defined by Brink et al., (2012:57) as the actual collection of Information. Grove et al., (2013:536) defined data collection as a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study.

Data collection procedure is mainly identified during the proposal phase of the study, Christensen, Johnson and Turner (2011:274) mentioned that a researcher should adhere as closely as possible to the data collection procedure as planned.

For this study, the researcher followed steps identified by Waltz, Strickland and Lenz (2010:293-297) who identified the steps to be followed in a qualitative research when using interviews as a method of data collection. The purpose of using these steps systematically is to improve the trustworthiness of the research findings. The steps followed in this study are as follows: constructing interview questions, piloting, and conducting interviews.

3.4.4.1. Constructing interview questions

The researcher is the main data collection tool for this study. However, in order to guide the researcher, an interview schedule was designed as stated in Breakwell (2012:367).

The questions were formulated based on the objectives of the study, research questions and findings from literature review. The questions were divided into three categories, namely biographic data, the grand tour question and follow-up questions (See Annexure D for the sample of questions which were used). Probes were formulated based on participant's response to questions.

3.4.4.2 Pilot study

A pilot study is a micro version of the main study to assess how adequate and feasible the main one will be (Moxham 2012:35). This process will facilitate identification of potential problems and taking of remedial action. Before conducting the actual data collection the researcher conducted an initial study with one of the adolescents who met the inclusion criteria. The interview was audio recorded and it lasted for only 15 minutes. The researcher transcribed the interview and submitted it to the study supervisor. The supervisor reviewed the transcript and gave comments on the proper phrasing of questions, use of minimal encouragers and probes. Based on the feedback, the interview guide was revised. The researcher interviewed the second person following feedback from the supervisor. The interview lasted for 45 minutes.

The researcher submitted the transcript to the supervisor who then gave the go ahead to the researcher to continue with proper data collection.

3.4.4.3 Conducting interviews

Snowball sampling was used. As each participant referred a friend or peer the individual was contacted. Those who showed their willingness to participate were invited for interview. The researcher's office was used to conduct the interviews as it afforded privacy to the participants. The researcher arranged in advance with the gate keepers of different venues to get a private and quite space. The researcher also planned to maintain the SOLER technique as described in Egan (2010:37). SOLER is an acronym for the following:

- S: Sit squarely facing the participant.
- O: Open posture meaning that the interviewer should not cross the legs or arms.

- L: Lean slightly forward towards the participant.
- E: Eye contact with participant.
- R: Relax, which means that the interviewer should not be fidgeting with any items, or writing field notes.

The researcher welcomed each participant and recapped the information provided during the information session which included information about the research, its significance, the significance of their inclusion and participation, the confidentiality of data, voluntary participation and that the participant could withdraw from the study at any time without even explaining the reason for withdrawal. The information leaflet was again given to each participant to enhance understanding of the study (Annexure E). All participants demonstrated understanding of the study, and subsequently indicated their preparedness and willingness to participate in this study by signing the informed consent (Annexure-F).

After receiving informed consent from each participant to conduct the interview and to record the interview; the interview was commenced with general information to create rapport. When the participant was relaxed, the researcher used the following central question to initiate the interview: *“Kindly tell me your perceptions regarding HIV and AIDS”*. Other questions emanated from this central question. Prompts were utilised to explore the perceptions, feelings, reactions and participants’ interpretation of each reaction and the various responses. Specific probes were also identified to ensure that each participant was asked about more or less similar aspects. The estimated duration of each interview was 45-60 minutes. The data collection process continued until all themes that had emerged had been exhausted and data saturation had occurred. Field notes were taken to ensure that the researcher recorded what she had heard or seen e.g. tone of voice, changes in facial expression; these are aspects that cannot be determined by listening to recorded information.

3.5 DATA MANAGEMENT AND ANALYSIS

Data analysis is a systematic organisation and synthesis of the research data (Polit & Beck 2012:725). In qualitative research, data analysis is conducted concurrently with data collection (Botma, Greeff, Mulaudzi & Wright 2010:220; Smith et al., 2009:79).

Data in qualitative research is non-numerical, and usually in the form of written words or videotapes, audiotapes and photographs. Analysis of data therefore involves an examination of text rather than the numbers that are considered in quantitative studies (Brink et al., 2012:193). The voice recordings were listened to a number of times before transcribing. Listening to the recordings and transcribing of information was done on the same day as the interview to assist the researcher to have a 'fresh' frame of reference. The data was transcribed from the voice recorder into a written format. Field notes were also referred to for additional information pertaining to the non-verbal cues of the participant during each interview. This increases the accuracy of data collection. Interpretative Phenomenological Analysis framework for data analysis was used for data analysis as described in Watson, McKenna, Cowman and Keady (2008:375).

The data was analysed using Interpretive Phenomenological Analysis (IPA) framework for data analysis. According to Langdridge (2007:13) this type of phenomenological analysis facilitates understanding of in-depth accounts of research participants. The analysis was done in stages as reflected below:

The first stage of data analysis was about "*reading and re-reading*" the transcript several times. The first reading of the transcript was done at the same time as listening to the audio recording related to the particular transcript. Smith and Osborne (2009:82) stressed that IPA analysis involves researchers' self-immersion in the data through reading transcripts more than once. This was done at least twice for each transcript. Stage two involved "*initial note taking*"; as the researcher continued to read the transcripts comments were made reflecting similarities, differences, anything of interest or significant about research participants' perceptions. The process led to "*developing emergent themes*". From the potentially important and provisional notes, the researcher

noted the interrelationships, connections and patterns that emerged in data. These were developed into themes reflecting participants' meanings from the narratives. The next stage was about "*searching for connections across emerging themes.*" This involved exploration, fitting and drawing together all related themes.

This data analysis process resulted in the formulation of a master list containing superordinate themes, sub-themes and related quotes from transcripts highlighting different parts of the transcript where the information on each theme was found. The final step was to compile a single master table of themes.

The following superordinate themes emerged from the data analysis and are discussed in chapter four with extracts from participants' narratives:

- Knowledge regarding HIV and AIDS.
- Views regarding HIV programmes
- Attitudes towards people living with HIV and AIDS

3.6 ETHICAL CONSIDERATIONS

Ethics in research deals with what is proper and improper in the conduct of scientific inquiry (Streubert & Carpenter 2011:62). For this study, the researcher has considered the following ethical issues: permission to conduct the study, informed consent, self-determination and withdrawal, anonymity, confidentiality and privacy, non-maleficence, beneficence and guiding against researcher misconduct.

3.6.1 Permission to conduct the study

The researcher first submitted a proposal to the University review board and was granted approval to conduct the study from the Ethics Committee of the University of South Africa. Ethical clearance was provided by the Health Studies Higher Degrees Committee. The ethics certificate number is HSHCD/477/2015 (Annexure A).

3.6.2 Informed consent

According to Medical Translation Services (2015:1) the individual must have sufficient knowledge and understanding of the nature of the proposed research, the anticipated risks and potential benefits, and the requirements of the research to be able to make an informed decision. Moule and Goodman (2014:63) refers to informed consent as the process of gaining agreement from an individual to participate in a research study, based on having been given all relevant information, in a manner that is appropriate for that individual, about what participation means, with particular reference to possible harms and benefits as well as the inclusion criteria. The researcher telephoned each participant and explained the purpose of the study and the nature of the research activities. A face to face meeting was arranged with each participant and the ethical issues were discussed with the participant. The participants were given all necessary information as outlined in the Information brochure to participants (Annexure C). Once the participant verbalised that he/she fully understood then only was informed consent (Annexure B) obtained from the participant. Participants also had to give permission for the interview to be recorded (Annexure B). Only one participant refused to have the interview recorded and this was respected and adhered to. Informed consent is the voluntary agreement of an individual, or his/her authorised representative, who has the legal capacity to give consent, and who exercises free power of choice, without undue inducement or any other form of constraint or coercion to participate in research. Once the participant verbalised that he/she was willing to be interviewed informed consent to participate as well as consent to be audio recorded was obtained before the interview commenced.

3.6.3 Self-determination and withdrawal

Individuals are autonomous. They have the right to self-determination. This implies that an individual has the right to decide whether or not to participate in the study, without the risk of penalty or prejudicial treatment (Brink et al., 2012:35). In addition he/she has the right to withdraw from the study at any time, to refuse to give information and to ask

for clarification about the purpose of the study (Brink et al., 2012:35). The researcher respected these rights by avoiding any form of coercion of the participants.

3.6.4 Anonymity

Anonymity literally means namelessness (Brink et al., 2012:37). Grove et al., (2013:172) state that anonymity exists if research participants' identity cannot be linked with individual responses. The process of ensuring anonymity refers to the researcher's act of keeping the participants identities a secret with regard to their participation in the research study. In qualitative research total anonymity is not possible as interaction is face to face (Brink et al., 2012:37). Each participant can be provided with a number or a codename. The master list of participants' names and codenames should be kept in a safe place. The list with the real names should be destroyed (Brink et al., 2012:37-38). The researcher ensured anonymity by allocating a number to each participant and ensuring that all recorded interviews and written demographic data that could identify a participant, was stored in a locked cupboard in the researcher's office.

3.6.5 Confidentiality and privacy

According to Grove et al., (2013:690) confidentiality in research refers to the management of private data so that participants' identities are not linked with their responses. Confidentiality, according to Babbie (2010:67) refers to the researcher's responsibility of making sure that the information obtained during the course of the study is not divulged to any other person without the permission from the study participants. Confidentiality pertains to how personal information is managed to ensure that only the researchers directly involved in the study have access to the information and that information is not willingly or unintentionally shared with other people unless the person has consented to sharing the information (Botma et al., 2010:17). A confidentiality clause was included in the agreement between the researcher and the individual. This indicated that the name of the participant would not be mentioned in any publications and would only be referred to by the allocated number. The researcher

ensured that the identity of individual participants will not be revealed in the findings and permission will be acquired when direct quotes will be used.

Study data was labelled by referring to participants by their allocated numbers. All recorded interviews and written demographic data that could identify a participant, was stored in a locked cupboard in the researcher's office during the period of studies and for at least five years after completion of the study. Privacy refers to an individual's right to determine the time, extent and circumstances under which personal information can be shared or withheld from others (Grove et al., 2013:169). To ensure privacy, all interviews were conducted in the researcher's office. Participants were requested to share only information which they were comfortable to share.

3.6.6 Non-maleficence

The principle of non-maleficence refers to the researcher's responsibility and duty to avoid, prevent or minimise harm to research participants (Babbie 2010:71). According to Rees (2011:103) the researcher has an obligation to protect the rights and welfare of research participants. In this study, the researcher was sensitive to asking questions that triggered emotions. Questions were asked in a respectful manner. In instances where the participants were reluctant to share some information they were not forced to do so. The psychologist was on standby to counsel the participants in case they became emotionally disturbed by some of the questions or just by participating in the studies.

3.6.7. Beneficence

The principle of beneficence refers to maximising benefits versus risks in a study and preventing any harm (Moule & Goodman 2014:57). Though there was no direct financial benefit to the participants, after interview, the recommendations based on their participations will be utilised to improve HIV and AIDS information to other Indian adolescents. Participants were also informed that if they needed any further information related to HIV and AIDS they may contact the researcher.

3.6.8 Research misconduct

Research misconduct is defined as fabrication, falsification, or plagiarism in processing, performing or reviewing research, or in reporting research results (Grove et al., 2013:708). In this study, the researcher acknowledged all the academic work of other researchers as a way of limiting fraudulence and plagiarism, and maintained professional ethics and research conduct throughout.

3.7 MEASURES TO ENHANCE TRUSTWORTHINESS

Moule and Goodman (2014:188) describe trustworthiness as a method of establishing or ensuring scientific rigor in a qualitative research without sacrificing relevance. Grove et al., (2009:132) stated that rigour or trustworthiness is a means of demonstrating the plausibility, credibility and integrity of the qualitative research process. Lincoln and Guba (1985) in Polit and Beck (2012:745) define trustworthiness as the degree of confidence qualitative researchers have in their data assessed using the criteria of credibility, transferability, dependability, confirmability, and authenticity. This study followed the framework of trustworthiness posited by Lincoln and Guba (1985 cited in Polit & Beck 2012:175).

3.7.1 Credibility

Polit and Beck (2012:585) refer to credibility as confidence in the truth of the data and data interpretations. The supervisor offered constant and regular guidance to the researcher throughout the study as well as assisted in the validation of main and sub-themes. The researcher ensured true value of member checking and triangulation of transcribed data and field notes.

3.7.1.1 *Prolonged engagement*

The researcher ensured true value of the research under study through prolonged engagement in the study site in order to gain in-depth understanding of the

phenomenon under study (Bothma et al., 2010:231). The researcher had telephonic information sessions with the participants during the preparatory phase to establish rapport. This enabled the participants to be comfortable with the researcher and that provided a platform for trust, which in turn resulted in open and free discussions. The researcher asked the participants to contact her at any time to respond to any queries they may have had.

3.7.1.2 *Member checking*

In ensuring the truth of the data, the researcher went back to the participants to provide feedback about emerging interpretations and to seek clarifications of some aspects of participants' responses (Polit & Beck 2012:591). Participants were able to clarify the issues discussed with them.

3.7.1.3 *Triangulation*

Data triangulation was also used to ensure credibility of the study as the researcher collected data using interviews and observations. The researcher used semi-structured interviews and field notes as means of ensuring triangulation (Polit & Beck 2012:590).

3.7.1.4 *Peer debriefing*

Peer debriefing is one of the quality enhancement strategies that involves external review and also involves sessions with peers to review and explore various aspects of the inquiry (Polit & Beck 2012:594). The researcher presented her summary of the findings to her supervisor; other qualified and experienced researchers from her workplace. Suggestions for improvement were made and incorporated in the findings.

3.7.2 Transferability

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck 2012:745).

The researcher followed theoretical parameters of the research processes of data collection and analysis, and these guaranteed transferability of the findings to other settings. The dissertation report contains a detailed description of the perceptions of young Indian adolescents towards HIV and AIDS.

3.7.3 Dependability

Dependability refers to evidence that is consistent and stable (Polit & Beck 2012:585). In this study data triangulation was ensured to achieve consistency. The researcher conducted the 'pilot study' prior to the study to assess whether the research questions will be answered, and the same questions were asked to each participant. The research methods of data collection and analysis were explained to the participants in detail during contact sessions.

3.7.4 Confirmability

Confirmability refers to accurate reporting of the real meaning of data as provided by the participants (Brink et al., 2012:171). The researcher strived to establish that the data represent the information participants provided and that the interpretations of those data are not the inventions and biases of researchers. Thus, the researcher employed bracketing in the study (Polit & Beck 2012:495).

3.7.5 Authenticity

Authenticity refers to the extent to which the researcher fairly and faithfully shows a range of different realities. Authenticity emerges in a report when it conveys the feeling tone of different realities (Botma et al., 2010:234).

The researcher made it possible for the readers to be able to understand the reasons for the perceptions of young Indian adolescents towards HIV and AIDS.

3.8 CONCLUSION

This chapter focused on the methodology of the research process, which was used to explore the perceptions of young Indian adolescents towards HIV and AIDS. Steps

followed to ensure that the ethical principles of research are not violated are elaborated. Measures employed to ensure trustworthiness of the study were also discussed in this chapter. The next chapter focuses on the results of the study.

CHAPTER 4: RESULTS

4.1 INTRODUCTION

Chapter three addressed the research design and methodology. This chapter presents the findings of the research. The findings describe how young Indian adolescents in the Chatsworth community perceive HIV and AIDS. This was based on the data collected with the participants using Interpretative phenomenological design. The data in qualitative research is non-numerical and are usually in the form of written words or videotapes, audiotapes and photographs (Brink et al., 2012:193). Data were analysed qualitatively using the principles of IPA framework of data analysis. Three superordinate themes, themes and sub-themes derived from data analysis emerged from data analysis process. The superordinate themes that emerged were: knowledge regarding HIV and AIDS, views regarding HIV programmes and attitudes towards people living with HIV and AIDS. Results are presented in this chapter focusing on demographic data and the emergent themes.

4.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS

The purpose of providing the demographic data is for the readers to understand the sources of the information. It is also used in qualitative data as a means of ensuring transferability, as participants characteristics are described to allow for comparability of findings in settings similar to the one studied (Bryman et al., 2014:45). The demographic data of participants are displayed in Table 4.1.

Table 4.1: Demographic profile of research participants

Participant	Age	Sex	Educational level	Number of years in Chatsworth	Sexual involvement
1	19 years	Female	2 nd year university student	17 years	Never been sexually active
2	19 years	Male	Grade 12	19 years	Sexually active
3	18 years	Female	Grade 12	18 years	Never been sexually active
4	18 years	Female	1 st year nursing student	18 years	Never been sexually active
5	19 years	Male	1 st year university student	19 years	Never been sexually active
6	18 years	Female	1 st year university student	18 years	Never been sexually active
7	19 years	Female	2 nd year university student	19 years	Never been sexually active
8	19 years	Female	Grade 12	19 years	Never been sexually active
9	18 years	Male	Grade 12	18 years	Sexually active

4.3 PRESENTATION OF FINDINGS

Several themes and sub-themes aligned to each superordinate theme emerged as depicted in Table 4.2. In the presentation of results, themes and sub-themes are supported by verbatim statements made by participants in order to substantiate relevance in the results.

Table 4.2: Superordinate themes and sub-thematic categories

Superordinate theme	Theme	Sub-theme
4.3.1. Knowledge of HIV and AIDS	4.3.1.1 Difference between HIV and AIDS	<ul style="list-style-type: none"> • What are HIV and AIDS? • Physiological response/Effects on the body
	4.3.1.2 Mode of spread of HIV	<ul style="list-style-type: none"> • Sexual transmission • Non-sexual transmission
	4.3.1.3 Prevention of HIV	<ul style="list-style-type: none"> • Use of condoms • Other methods of prevention
	4.3.1.4 Management of HIV	<ul style="list-style-type: none"> • Medication compliance • Lifestyle changes
	4.3.1.5 Behavioral determinants	<ul style="list-style-type: none"> • High risk behaviours • High risk groups • Risk perception

Superordinate theme	Theme	Sub-theme
	4.3.1.6	<ul style="list-style-type: none"> • Medication
	Misconceptions	<ul style="list-style-type: none"> • People at risk • Mode of spread
4.3.2 Views regarding HIV programmes	4.3.2.1	<ul style="list-style-type: none"> • Sources
	Programme content	<ul style="list-style-type: none"> • Relevance of information
	4.3.2.2	<ul style="list-style-type: none"> • Participant attitudes toward programmes
	Delivery of programmes	<ul style="list-style-type: none"> • Participant attitude toward facilitators
4.3.3. Attitudes towards people living with HIV and AIDS	4.3.3.1	<ul style="list-style-type: none"> • Participants' attitudes about
	Positive perceptions	<ul style="list-style-type: none"> • people living with
	4.3.3.2	<ul style="list-style-type: none"> • HIV and AIDS
	Negative perceptions	

4.3.1 Knowledge of HIV and AIDS

This theme is about the information which young Indian adolescents have regarding HIV and AIDS. It relates to difference between HIV and AIDS, mode of spread, prevention of HIV and AIDS, management of HIV, behavioral determinants and misconceptions.

4.3.1.1 Difference between HIV and AIDS

This section deals with how participants differentiate between HIV and AIDS.

The interview revealed a high level of knowledge among the participants with regards to perceptions of what HIV is but minimal knowledge about what AIDS is. All participants were aware that HIV is an incurable viral disease. This was indicated by statements such as:

“What comes into my mind when I hear the words HIV and AIDS is that people with this disease are going to die. HIV is a very dangerous virus which is

incurable. I also know that HIV causes AIDS. Well I know that it is a disease that is not curable ... and that it is caused by a virus” (Participant 7).

4.3.1.1.1 Effects of HIV and AIDS on the body

Participants realised that the main effect of HIV infection was on the immune system.

“My understanding of HIV is that if you have HIV, it affects the immune system. Your immune system starts to deteriorate. I’m not sure about the biology behind it though. I know that it is a virus and it affects the body’s immune system and the person can become severely malnourished” (Participant 5).

“....and it affects the immune system as you go through the various stages” (Participant 4).

Only one participant knew that AIDS was a progression of untreated HIV as the participant is a nursing student. The other 8 participants stated that HIV and AIDS were the same disease.

“I understand that HIV positive means that you have become infected with the HI virus while when a person gets AIDS it means that their viral load is very high, like the last stage of HIV infection and their organs get damaged which can result in death. But before I started nursing, HIV and AIDS were the same for me and it meant that a person will die soon” (Participant 4).

4.3.1.2 Mode of spread for HIV

This section deals with participants’ knowledge of how HIV and AIDS is spread.

4.3.1.2.1 Sexual transmission of HIV

Participants were aware of different modes by which HIV can be spread. All of them were in agreement that HIV is a sexually transmitted infection.

This was shown by the following excerpts from the interviews with participants 2, 3 and 5 respectively.

“My understanding of HIV and AIDS is that it is a sexually transmitted disease or infection that you can get by having unprotected sex” (Participant 2).

“Some people get it through being raped by a person who is HIV positive then the victim can become infected as well” (Participant 3).

“... and, uh, sometimes you can be wearing protection but if you use it, condoms, I mean incorrectly then you can still be exposed to it” (Participant 5).

4.3.1.2.2 Non-sexual transmission of HIV

However, some of the participants were also aware that HIV can be spread through other modes as asserted by the following quotation by participant 1.

“People who come into contact with blood, such as nurses and doctors, if they do not use gloves; as well as people who receive blood that is not tested correctly; also drug users who share needles. I think a baby can get it if the mother is infected and breastfeeds the baby. Oh, also the pregnant mother can give it to her unborn baby but I’m not sure how that happens” (Participant 1).

4.3.1.3 Prevention of HIV

This section deals with participants’ information regarding the means of preventing HIV and AIDS.

4.3.1.3.1 Use of condoms

Participants were aware of different methods by which HIV could be prevented. All of them were in agreement that the use of condoms during sexual intercourse was an effective way to lower the risk of being infected with HIV. This was asserted by the following statement.

“I use protection because that’s one of the ways to prevent yourself from getting HIV” (Participant 9).

Participants were also aware that promoting the use of condoms was not effective if correct use of condoms was not known.

“Health education, uh, people need to be educated to act smart. It’s no use giving free condoms if they don’t know how to use it. So I also think that they should use gloves and aprons, because sometimes people have to take care of their relatives at home and they come into contact with blood and other body fluids” (Participant 4).

4.3.1.3.2 Other methods of prevention

However, some of the participants were aware that there were other strategies that could be used to prevent the spread of HIV as asserted by the following quotations.

“As I said before ,doctors and nurses need to use gloves when giving injections or touching blood; not sharing sharp things like needles and shaving blades; blood that is donated must be tested thoroughly” (Participant 1).

“I think in today’s day and age everyone should be tested before they start being intimate with another person because you don’t know who is positive and who is not and also don’t have one night stands. You should not be intimate until you are in a solid relationship like being married” (Participant 8).

“Avoid places like nightclubs because I heard that they spike your drink with some drug that makes you lose your mind and you can end up having sex or even getting raped by a stranger. If you go to night clubs then go with friends because if you are with others then they will know that you are missing; also don’t leave your drink open because anyone can put anything into it” (Participant 8).

4.3.1.4 Management of HIV

This section deals with participants' perception of how HIV can be treated and managed.

4.3.1.4.1 Medication compliance

Participants were aware that antiretroviral drugs were the treatment of choice for HIV infection but had minimal insight into how the drugs affected the HI virus.

"I know they take tablets called ARVs. I'm not sure how it works though"
(Participant 1).

Some of the participants were aware that ARVs slowed down the progress of the disease and that they needed to be taken chronically to control the infection.

"If you are HIV positive then you need to take your ARVs so that you can slow down the progress of the disease" (Participant 9).

"I know that the medication is called ARVs and that they have to take it for the rest of their lives otherwise the disease would get worse" (Participant 6).

4.3.1.4.2 Lifestyle changes

Participants were also aware that there were non-pharmaceutical methods of managing HIV infections which included lifestyle changes such as eating a healthy diet, avoiding people with infections and hygienic preparation of foods.

"The nurses told us that they also had to eat healthy and not to be with people who had the flu because if they got the flu they would land up in hospital because their immune system was weak. Like they had to eat a lot of fresh fruits and vegetables so that they could get energy and they had to wash it before eating because if they got diarrhoea from eating dirty fruits and vegetables then it could harm them more. The nurses also told them about using condoms but the lady did not listen she went back to sleeping around and then she got very sick and

she died; the guy I think used condoms because he is still alive and doing well” (Participant 9).

4.3.1.5 Behavioural determinants

This section deals with participants’ perception on behavioral determinants that put a person at risk.

4.3.1.5.1 Risk perception

The female participants viewed themselves as at low risk for being HIV positive as they did not engage in behaviours that put them at risk especially behaviours related to sexual activity. Their abstinence was related to cultural and religious taboos.

“I don’t engage in any of the things that could get me infected. I don’t use injectable drugs and I don’t have a boyfriend. If I had a boyfriend I would only be intimate with him after we are married as I am a Christian and I don’t believe in premarital sex; the Bible tells us that sex before marriage is a sin” (Participant 1).

“... but you know how people in our community look down on girls who sleep around. It is okay for boys, everyone thinks it’s normal when boys have many girlfriends but when girls do the same thing then it’s a big problem; everyone thinks that they are fast. It’s always about what the neighbours will say; that is why I am very careful what I do because people can misunderstand and cause gossip which would bring shame to my family (Participant 2).

The male participants however, except one, admitted to being sexually active but also saw themselves as being at a low risk of being infected because they always used condoms when engaging in sexual intercourse. The one participant was not sexually active due to his Christian religious beliefs.

“I’m all for it (using condoms); I don’t want to get any diseases. I would use a condom if I had to sleep with a girl” (Participant 2).

4.3.1.5.2 High risk behaviours

Although the participants had verbalised that they themselves did not engage in high risk behaviours, two participants stated that their friends and peers, both male and female, did in fact engage in casual high risk sexual behaviours, especially at university. Both the participants attended two different universities.

“Like on campus, when they like each other they are going to do something about it even though they don’t know each other well, but I guess that lack of a relationship becomes their downfall at the end of the day. They go off campus and do their thing (have sex) and come back. Everyone knows what is going on; but I do know that a lot of college guys have unprotected sex on campus with girls from campus. They cut lectures and they have their places that they go and do their thing. They are aware of the risks but they still have unsafe sex. Like my friend who had a scare and had his HIV status checked.

He came and confided in me that he went to a prostitute and had unprotected sex but he was now scared. He is one of the guys that go off campus because there are a lot of prostitutes that hang around outside campus” (Participant 4).

“At campus you see the students, they wouldn’t care were they were; they were very sexually active; I mean full blown sex. I am not sure if they used condoms because I was not friends with them” (Participant 7).

It also appears that some younger boys engage in casual sexual encounters with older women. These young boys are flattered by the attention and the “bragging rights” that they get by associating with these women.

“Ja! but women too also play their part, they are not without blame. They too come onto us and the way they dress you know that they are available. But when the women dress with revealing clothes then you know you got it made. These women also drink and smoke drugs and all so you know which type is which. Ja! they want you must buy them jewelry and take them to the movies and all. Ja! just because we like small and all don’t stop them. Guys like us that are hustling

we don't get many of them but sometimes they come to us when they like desperate and the rich okes are not around. We buy them cigarettes and all and then we like the boss" (Participant 9).

High school children are also engaging in high risk behaviours such as alcohol consumption that leads to loss of inhibitions resulting in unplanned sexual encounters. These encounters occur in the absence of parental supervision as parents are at work and the children home alone with no adult supervision.

"Hey, when we were in school, the girls they drink and smoke and they come onto us right in the school grounds. They don't worry about the teachers. Ja, hey! They even buy the drink and wait for us after school and we drink together on the road. Sometimes, they even invite us to go to their houses because their parents are working and no-one is at home. The fast girls are the ones that do these things; we know who they are because boys talk, you know, and so certain girls got like a reputation for being easy" (Participant 2).

4.3.1.5.3 High risk groups

All participants agreed that prostitutes and their clients were high risk groups for contracting and spreading HIV infections.

"... Because prostitutes are one of the main people who are HIV positive and then spread it to their clients and then these men go home and infect their wives. These women (prostitutes) don't use protection. If these men's' wives are pregnant and they get infected then they spread it to their unborn babies. "(Participant 7)

The male participants agreed that older men, over 50 years, were more at risk of being infected than females because of their tendency to use prostitutes as well as they were more likely to be unfaithful to their wives and not only with prostitutes.

"Due to prostitution and cheating on their wives with other women who are not prostitutes, but I think prostitution is a major problem because you see people stop and pick up these women and they are older men, like in their 50s, or you

see their cars parked outside these places that we all know are where prostitutes operate from” (Participant 5).

4.3.1.6 *Misconceptions*

This section deals with participants’ misconceptions about HIV and AIDS.

4.3.1.6.1 *Treatment*

Very few misconceptions prevailed among the participants regarding the pharmacological treatment of HIV. All participants were aware that ARVs were used to treat HIV infections but none of them were aware of its actual mode of action as depicted by the following statement by participant 1 and corroborated by participant 6.

“... but I think that it prevents the person who is infected from spreading the disease to someone else” (Participant 1).

“I know that the medication is called ARVs and that they have to take it for the rest of their lives otherwise the disease would get worse but I don’t know how the ARVs actually work on the body (Participant 6).

4.3.1.6.2 *People at risk*

Misconceptions regarding people at risk were also noted. Most participants did not think that people in Chatsworth were at risk as they had not come across anyone in their area with HIV.

“I don’t think there are any people in Chatsworth that are HIV positive. I haven’t seen anyone or heard of anyone being HIV positive. If anyone was suffering from this disease then everyone would be talking about it “(Participant 1).

Some of the participants believed that people from low socio-economic and rural areas were more at risk than anyone else because of poor hygiene and overcrowding.

“People from rural areas and poorer districts with overpopulated areas are more at risk than anyone else because I will say because of the unhygienic conditions and overcrowding” (Participant 4).

Two participants stated that one race group was more at risk than another i.e. Blacks were more at risk than any other race groups; however this was due to the media coverage that they had been exposed to as well as the high risk behaviours that was observed on campus.

“I also think that mainly black people get HIV more than other people. I’m not a racist or anything but, you know whenever there is anything to do with AIDS there is always pictures of black people “(Participant 2)

“... but to be fair it was not the Indian students who were doing this (having sex) it was mainly the black students; you know things like having sex right there on campus. Anyone walking pass could see them, they just didn’t care. The Indian students, you would see them sometimes kissing, like really hot and heavy, but they were not like doing full sex because you could see them like their clothes were on and all. The Indian boys did sometimes leave the campus, you know like bunk afternoon lectures and you would see them paying the girls outside the campus, on the road; we like all knew that they were prostitutes” (Participant 7).

4.3.1.6.3 Mode of spread

A common misconception that was prevalent among both male and female participants was that being in a steady relationship, like marriage or with a view to marriage guaranteed faithfulness by the other partner. The belief was that if they were faithful then the other partner would be faithful so there was no need for HIV testing or the use of condoms.

“... I would use a condom if I had to sleep with a girl... but if we were going steady and planned to settle down and she was on the pill then I wouldn’t worry about it; because then we would be faithful to each other, right?” (Participant 2)

“When I am married I will be faithful to my husband and he obviously would be faithful to me. I guess I will just have to trust him like it is in most marriages; not everyone goes and get tested before they get married even if their husband has been with other women” (Participant 1).

4.3.2 Views regarding HIV programmes

This theme is about the views of Indian youth who participated in the study towards HIV programmes that they have been exposed to, their effectiveness and relevance. This theme also focuses on participants’ perceptions about the method of delivery as well as the facilitators who deliver these programmes.

4.3.2.1 Programme content

This section deals with the main sources utilised by participants to get information about HIV and AIDS.

4.3.2.1.1 Sources of information

All participants agreed that most of their embedded knowledge regarding HIV and AIDS was from high school where they were taught about HIV and AIDS in Life Orientation. They also agreed that Life Orientation provided information on how HIV is spread and how to prevent HIV but did not focus on AIDS as a separate disease. HIV prevention programmes from outside groups that were held at school were also an important source of information.

“We learnt quiet a lot in Life Orientation and then you get people coming to school to give talks as well and those talks were very informative” (Participant 8).

“Uh, we learnt about ways that you can get HIV and how it is prevented but we didn’t learn too much about AIDS. If I can remember correctly we were just taught that it was a complication of HIV if HIV was not treated correctly” (Participant 5).

Those participants who attended tertiary educational institutions were further exposed to HIV programmes on campus to varying degrees. However, among the four participants who attended university full time, only two agreed that the universities they attend provide some form of HIV intervention programmes.

“We do get groups of people that come to campus and have talks and short programmes about HIV and AIDS. Mostly this occurs around November and December as I think around this time is International HIV and AIDS day or something to that effect. This occurs very sporadically and these programmes are not very well organized. There is always some form of delay and we don’t stay long as we have to go on to the next lecture. Having these programmes is a good idea but it needs to be better organized” (Participant 7).

The other two participants were not aware of any HIV prevention programmes at their institutions although they had been there approximately six months at the time of interview.

“No-one comes and talks to us about HIV. I guess they think that because we are student nurses then we should know but it would be nice if we got some information about experiences of people who are actually living with HIV. It is very difficult as a student nurse to talk to patients about their condition because of time and also because of other patients being around; so we only know what the textbooks tell us but the human aspect is not there which as nurses is the most important” (Participant 4).

“I am just in my first year so I don’t know if they have had programmes in previous years but no, nothing since I have been here and I have been on campus for 6 months. It would be nice to get this information” (Participant 6).

Only one participant had used the internet to obtain information about HIV infections due to self-interest because two people very close to him were HIV positive.

“I know two people who are very close to me who are HIV positive and one passed away recently. So when they told me that they are HIV positive then I

went and found out more information on the internet and also on watched programmes on TV. The internet has some very good information about what to eat and how to cope with side effects of the medication. I discussed these issues with my friends and it did help them” (Participant 9).

4.3.2.1.2 Relevance of information

The four participants who attended university full time agreed that the HIV programmes at university held no interest for them because it was not informing them about anything new.

The information was not different from what they had learnt at school in Life Orientation with regard to: mode of spread and prevention. They wanted information that was relevant to their age and lifestyle practices of their age group. It was felt that due to sexual behaviour on campus the information should focus on educating students on when and how to use condoms, the importance of sexual fidelity and the importance of HIV testing.

“I’m not being funny but it has just become another topic that you talk about, and also being a student at campus is different from school. In school it wasn’t so, the topic about sex; it wasn’t so exposed like on campus. On campus it’s a real thing, students, first years and second years, they exposed to these things and there aren’t people there to say you know what this is wrong this is right. On campus I noticed they encourage safe sex which is good but that’s all they do. They hand out condoms but they don’t advise on how to use the condoms and like when to use it, also talk to us about things like why it is important to have one partner and be faithful to that partner, like, say guys this is serious, you can die, and it can affect your whole life if you don’t take basic precautions. We, obviously, we hear stories from other people but it’s only when we are affected by it that it’s a reality, and then it’s too late. So my whole idea about HIV and AIDS is it’s there, it’s serious but it’s not so well exposed. So, ok, they do advertise and say it’s out there but the seriousness of the situation is not communicated.” (Participant 5)

It was suggested that information should be more scientific, visual and more graphic. It was suggested that if their peers were more aware of how HIV affected their body internally that is: the immune system and saw pictures or interviews of people presenting with severe symptoms then this shock tactic may prevent them from being so blasé' about this serious illness.

“Make it more scientific, like how it actually affects the body and the repercussions it has. Just telling us to wear condoms and abstain is not working. Get people who are HIV positive to come and tell us their stories. We are a generation who want to see events in real life. Also when you are scientific and show them evidence it becomes more of a reality. Like I know that HIV came from monkeys or chimps. I’m not really sure but very few of us actually know this” (Participant 7).

Most of the participants stated that they did not think that the information that they had learnt at school was relevant to them because their lifestyles precluded them from being at risk as indicated by the following statement.

“I read up on it when I was at school because we were tested on it; but I did not really need to know about HIV because I was not doing anything, like sleeping around, to get HIV positive” (Participant 1).

4.3.2.2 *Participants views of HIV and AIDS programmes*

This section deals with participants' attitudes towards HIV information programmes and facilitators of these programmes.

4.3.2.2.1 *Participants' attitudes toward HIV programmes*

Most of the participants displayed a nonchalant attitude towards HIV programmes both in school and outside the school environment. HIV programmes outside the school environment included those that were offered on campus and in the communities within which the participants lived. The participants also stated that because there is so much of information about prevention of HIV being propagated that young people have lost

interest as well as they have lost sight of the severity of the problem affecting their age group.

“I mean the way they expose it, it’s not like wow that’s scary, maybe in other countries it will make an impact because it is not a reality to them but we are faced with it on a daily basis, and because of this people are not scared of it. I mean because it’s there. They know the risks, they know if you sleeping with a prostitute you will get HIV and AIDS but they still do it. So it means that the media has not made such an impact where that a person who wants to go sleep with a prostitute will say hey you know what I shouldn’t do that because that person may HIV and AIDS. That’s scary for me because I know this but it does not worry many others” (Participant 5).

All the participants stated that if they had had a choice in school they would not have chosen Life Orientation as one of the subjects that they had to do from grade 10 to grade 12. The underlying sentiment was that they did the subject under duress.

“I don’t know much else about how it can be spread because to be honest I never really paid much attention at school as it was not something that I found important. I used to focus on my other subjects like Mathematics and English literature because if I failed those subjects then I would fail the exam. Life Orientation was not really that important although it was compulsory to do and we had no choice” (Participant 2).

Those who attended campus displayed the same sentiment as their counterparts that did not attend campus i.e. they showed a marked lack of interest in HIV information as they also felt that there was nothing new to learn about HIV.

“We get people from the outside that come and talk to the students and all but it’s the same thing over and over again so I don’t attend. When we learnt about HIV in school in, Social sciences, I think then it was new information but now it’s the same thing we hearing all the time and people still do the same things , they don’t listen” (Participant 7).

Community projects fared no better as participants displayed the same apathetic attitude.

“... sometimes people come to the community hall and have campaigns but I don’t attend. Gosh it’s always on a Saturday and I feel too lazy to go; and anyway I don’t need to go as I am not intimate with anyone” (Participant 8).

It was also revealed that attending these programmes was tantamount to admitting that you were sexually active or HIV positive. To avoid this stigmatisation students did not attend the programmes, especially on campus.

“I think that may be because they are afraid that we will think that they are HIV positive and look down on them, like not want to associate with them.” (Participant 7)

Parental and societal disapproval was also a major reason for students not attending programmes or utilising services such as taking free condoms or HIV testing. Some participants felt that if they used the services provided and their parents found out negative sanctions such as “being grounded” would be imposed.

“You also see free samples in toilets and some people come to schools and give out free condoms and pamphlets but I didn’t take any when I was in school because if anyone saw and told my parents and then I would be in big trouble” (Participant 2).

It would also “disgrace the family name” if girls were seen to be using these services as the Indian community are more accepting of premarital sex among males than females. Attending these programmes would be seen as an admission of being sexually active without the benefit of marriage. This societal opinion would result in the girl’s reputation being destroyed and she would not be a good candidate for marriage. Therefore they do not attend these programmes unless they can prove that it is compulsory for whatever studies they are involved in.

“... That is why I am very careful what I do because people can misunderstand things and cause gossip which would bring shame to my family. People in our community are very judgmental. If they see you they want to know what you are doing and then they all talk about it. Even if we say it is for school they still will go and tell our parents where they saw us; and if you haven’t told your parents all hell will break lose. The one thing my mother always tells me is that I must behave otherwise no decent Indian boy will marry me. Even when I was in school and my mum used to see my Life Orientation books she was not very happy about what we were being taught as she thought that it would encourage me to want to experiment with sex and I would fall pregnant and disgrace the family” (Laughs) (Participant 5).

However some participants stated that Life Orientation and other school driven initiatives had made a great impact on them.

“With the protection and stuff, it helps me caution myself, also in the working environment to prevent it. Like, I know what will happen so I am more cautious. It is of interest to me because it concerns my health.” (Participant 4)

4.3.2.2.2 Participants’ attitudes towards facilitators of HIV programmes

Response to facilitators who taught or facilitated HIV information programmes varied according to the developmental age of the participants. When they were in school they were embarrassed and reacted in a childish manner but this behaviour could be attributed to emotional immaturity and not disrespect as the following response confirms.

“Also it was so embarrassing you know to hear our teachers talk about sex and all, they like our parents, I mean we know them from grade 8 and all and now they talking about things like that, you know, like ... uh...preventing pregnancy and using condoms. We all used to giggle a lot and act stupid too because we felt so shy” (Participant 2).

Some participants stated that they had no interest in programmes offered on campus because the facilitators themselves were disinterested. In their opinions the facilitators saw this as just another job that they had to do and get over with. They themselves displayed no interest or passion for what they were doing, thus students on campus responded in the same manner.

“The people who come on campus to educate us don’t show any passion for what they are doing. They are just there to do a job. So when we see them looking fed up then we disregard them and don’t listen. We play with our cell phones or put in our earphones and listen to music. They see us doing it but they just turn a blind eye because they are rushing off. They don’t even stick around to see if anyone has any questions. So they have these campaigns but they don’t focus on key aspects which should be advertising how dangerous and how life threatening and life changing it can be; how it can affect your family. They do have it but not in a vibrant eye catching way that will appeal to the youth. They need something they can interact with not something they have to sit and watch only. This is not going to help them” (Participant 5).

4.3.3. Attitudes towards people living with HIV and AIDS

This theme is about the attitudes of Indian youth who participated in the study regarding people with HIV and AIDS. This theme also focuses on participants’ positive and negative personal experiences with people living with HIV and AIDS as well as their positive and negative attitudes toward people living with HIV and AIDS.

4.3.3.1 Positive perceptions

This section deals with participants positive perceptions of people living with HIV and AIDS.

4.3.3.1.1 Understanding of people living with HIV and AIDS

Most participants had no personal or even casual encounters with people living with HIV and AIDS. One participant had personal experiences with caring for and supporting close friends who were HIV positive. He also had to deal with the experience of losing

one of these friends to an opportunistic disease; he was not sure what the opportunistic disease was; due to non-compliance to his treatment ARVs and continuing to engage in unprotected sex.

“I know two people who are very close to me who are HIV positive and one passed away recently. Actually, I don’t feel good inside because they were close to me. I used to take them to collect their treatment and to do their bloods. It helped them for a while but then they went back to their old ways. The nurses also told them about using condoms but the lady did not listen she went back to sleeping around and then she got very sick and she died; the guy I think used condoms because he is still alive and doing well” (Participant 9).

One participant was a student nurse so she had experiences with patients with HIV infections but no personal experience with people or a person living with HIV and AIDS.

“Just people at work, patients I mean. As a student nurse I have a lot of one-on-one contact with patients. When you see the patients suffering with the symptoms of opportunistic diseases, such as TB and meningitis, it is really sad. All your preconceived ideas, such as they deserve to become infected if they are sleeping around, just flies out the window. These experiences in the wards have changed my mindset about patients who are HIV positive. Now I am more empathetic toward them and this experience has helped me grow as a nurse as well. However, in my personal life I have not come into contact with any family member or friend that is either HIV positive or has AIDS or even anyone in my community. However, that may just be because people are not so open about being HIV positive because of the negative social stigma attached to being HIV positive” (Participant 4).

Most participants had a positive attitude toward people living with HIV and AIDS, especially if that person were a close friend or relative.

“I think that we should help them. It’s not their fault that they got the disease; so we should try to be there for them especially if they are our friends or family. If it

was someone close to me I wouldn't throw them away just because they slept around (Participant 3).

Participants were also sympathetic toward people who had become infected due to rape.

"It is not their fault if they got the disease if they were raped. No-one asks to be raped. It is different if the person was sleeping around and got infected. She would then have had a choice about using condoms and also she would have had a choice about how many men she wanted to sleep with. Rape is so traumatic and it is not as if you can ask the rapist to use a condom. I feel especially sorry for small children who are raped or molested. They are such easy targets and if they are infected they either die so young or have to live the rest of their lives with this condition "(Participant 3).

They also had the same attitude toward babies or children who had become infected due to mother to child transmission.

"I feel sorry for the babies and the children who are positive because they got it from their mothers and they couldn't help it" (Participant 8).

4.3.3.2 Negative attitudes

However participants displayed a less tolerant attitude toward people living with HIV and AIDS if it was due to promiscuity and non-compliance to the use of condoms.

"It's really sad, honestly, but they have put themselves in that situation by being intimate with someone and not using protection or a condom or not asking your partner to use protection; considering that condoms are free and so easily available. I can understand if you are married and your husband is unfaithful but otherwise I blame it on the people who sleep around, they asked to get infected, I mean everyone knows that sleeping around gives you HIV, but it is really sad" (Participant 6).

This sentiment was further corroborated by participant 7 with the following statement:

“They are human so I would react to them normal unless they deliberately put themselves in the situation like not using condoms or having a one night stand then those people have to live with the consequences of their actions” (Participant 5).

They were also scathing in their attitude toward mothers who infected their unborn babies.

“It is the parents’ fault if the baby gets it, and also there is so much information about HIV, no matter where you are so that if you do get infected because you were careless then you are at fault and no-one else is to blame; but to harm an innocent baby in that way, it is totally wrong” (Participant 7).

However, although most participants displayed some sympathy toward people living with HIV and AIDS as well as were well informed about mode of spread they were still uncomfortable with having physical contact with people living with HIV and AIDS especially if they had integumentary clinical manifestations.

“I would not be comfortable touching that person. I know that I can’t get HIV by touching someone who is HIV positive but I still feel uncomfortable. I’m not saying that they are dirty or anything but the pictures that I saw when I was in school showed that they have sores on their bodies and in their mouth....so that makes me uncomfortable.” (Participant 1)

This sentiment was reinforced by a comment made by participant 6.

“ it is not is not like I have something against them, you understand, but if I see someone that is HIV positive I wouldn’t want to hug them, even though I know that I can’t get it from hugging them. Like, I feel funny and don’t want to touch them” (Participant 6).

4.4 CONCLUSION

This chapter described findings of the research. The researcher provided detailed and expansive descriptions of the study findings pertaining to the perceptions of young

Indian youth who participated in the study towards HIV and AIDS. The next chapter will pertain to the discussion of findings, recommendations, limitations and conclusions of the study.

CHAPTER 5: DISCUSSIONS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The previous chapter presented the results of this study. This chapter summarizes, discusses and concludes the key findings from the study, provide appropriate recommendations arising from the study findings, as well as pinpoints the study's limitations.

5.2 RESEARCH DESIGN AND METHOD

This study used the qualitative interpretative phenomenological analysis design to explore the perceptions of Indian adolescents toward HIV and AIDS. Data was collected using semi-structured interviews. Nine participants were selected using judgmental purposive sampling.

Each interview lasted between 45 to 60 minutes. *Each interview commenced with the question “Kindly tell me your perceptions regarding HIV and AIDS.”* Communication techniques such as probing, paraphrasing and rephrasing were used during the interview in an attempt to obtain more information and to clarify misunderstandings.

The researcher used Interpretative Phenomenological analysis framework for data analysis to analyse data. Ethical principles were followed throughout the study. The trustworthiness of the study was maintained as the researcher followed Lincoln and Guba's criteria of credibility, transferability, dependability, confirmability and authenticity to increase the rigour of the study.

5.3 DISCUSSION OF THE RESEARCH FINDINGS

Following interpretative phenomenological analysis framework for data analysis, three superordinate themes emerged from data analysis.

The emergent themes are: knowledge regarding HIV and AIDS, views with regard to HIV programmes and attitudes towards people living with HIV and AIDS.

5.3.1 Knowledge with regard to HIV and AIDS

The findings of this study revealed that participants were well informed about the mode of spread of HIV, prevention of HIV, management of HIV and behavioral determinants such as high risk behaviours and high risk groups. These findings concurred with the findings of Shisana et al., (2014:74) that reported that South African whites and Indians were more knowledgeable about HIV transmission than their black and Coloured counterparts. American studies by Geevers et al., (2012:31) and Murray et al., (2011:34) also concurred with the findings of the current study; however not related to Indians specifically but to adolescents in general. However, the findings were inconsistent with Srivasta et al., (2011:87) and Verma et al., (2014:23) that reported that Indian adolescents in India had many misconceptions on how HIV was spread.

Participants of the study had a positive outlook on condom use and advocated for the use of condoms during all sexual encounters, unless one was in a monogamous relationship. Male participants that were sexually active had used condoms during all sexual encounters. These findings however were not consistent with Shisana et al., (2014:127) that reported inconsistent condom use; Richwood et al., (2014:543) that reported low condom use and Mhlongo et al., (2013:5) that reported no condom use during vaginal penetration. Participants all agreed that it was the responsibility of the male partner to use a condom during sexual intercourse. Once again these findings were inconsistent with Geevers et al., (2012:1131) that reported little agreement amongst participants about who in the relationship was responsible for using protection during sexual intercourse.

Female participants wanted to be more informed about sexual and reproductive issues although they were not sexually active, but were afraid to ask their parents or teachers as sex is a taboo subject between parents and children in the Indian community.

Their friends, and they themselves, get information from each other, which in many cases is incorrect. The general consensus among the female participants was that if they wanted to become sexually active they would not go to the clinic to get condoms as they were afraid of being seen by community members as this would result in negative

sanctions by their parents. These findings are consistent with studies by Farahani et al., (2012:103) and Srivasta et al., (2011:87) that reported that these cultural taboos contribute to the perpetuation of misinformation about sexual and reproductive health amongst conservative societies such as Iranians and Indians respectively. Male participants experienced more sexual freedom than their female counterparts as it was culturally and socially acceptable for men to engage in premarital sex.

It was agreed that HIV infections could be controlled by compliance to antiretroviral treatment and behavioral modification such as proper nutrition to build the immune system, use of condoms during every sexual encounter if not in a monogamous relationship and that HIV and AIDS could not be cured. These findings were inconsistent with Devieux et al., (2014:2019), Oladepo and Fayemi (2011:31) and Muthivi et al., (2011:586) who reported that belief in the supernatural as cause and cure of disease has resulted in noncompliance to ARV treatment and nonconformance to behavioral modification. Tun et al., (2012:462-463) reported conspiracy theory beliefs in post-apartheid South Africa that contributed to noncompliance to ARV treatment.

Transactional sex was cited as a growing phenomenon where females from poor families would exchange sex for luxuries such as jewelry, clothes and money with older men and approach the younger men for items such as cigarettes and alcohol. These young men were then held in high esteem by their peers because “they had what it took” to attract these women who generally fraternized with older richer men. This practice was also reported by MacPherson et al., (2012:7) and Dellar et al., (2015:66) where economic vulnerability was cited as the key motivation for transactional sex.

The study also showed that most of the participants were not sexually active due to cultural and religious beliefs, while those that had engaged in sexual intercourse had only had one sexual partner. This was inconsistent with findings by Zuma et al., (2010:47) who reported male youth 15-19 years of age had had concurrent multiple sexual partners. First sexual intercourse at occurred at 18 years of age. These findings were inconsistent with findings by Shisana et al., (2014:4) that reported age at sexual debut at younger than 15 years. The sexual relationships had been casual encounters.

It was also reported in this study that their peers on campus also engaged in casual sexual relationships; with the use of prostitutes being very rife. This was consistent with Geevers et al., (2012:1130) were youth reported preferring casual relationships as they were too young to settle down.

Most participants found it acceptable for young men to be sexually active if they were 18 years and older but the same rule did not apply to young women. This was seen as a sign of becoming a man. These findings were confirmed by de Vries et al., (2014:1087) where it was reported that in South Africa becoming sexually active at a young age was seen as a sign of masculinity.

Participants had a very low risk perception due to sexual practices i.e. females were not sexually active and males who were sexually active used condoms with sexual contact and would use at next sexual encounter. Low risk perception may also be attributed to the misconception that Indian people were not at risk of being infected and that black people were at the highest risk. This misconception could be attributed to HIV education programmes having mainly black actors as well as the sexual behavior of their peers on campus. This low risk perception was also reported by Shisana et al., (2014: xxxvii) and Geevers et al (2012:34).

5.3.2 Views with regard to HIV programmes

The main source of information for most of the participants was Life Orientation in high school as well as the information from programmes held at campus. This contradicts the findings of the studies by Muthivi et al., (2011:586) and Shisana et al., (2014:98) where radio and television were reported to be the main sources of HIV information for adolescents.

The importance of Life Orientation in the school syllabus has been validated by the study by Shisana et al., (2014:74) which reported that whites and Indians were more knowledgeable than their black and Coloured counterparts. Female participants were reluctant to access information from community driven HIV programmes as they feared

family and community censure. Discussing sexual and reproductive issues with their parents or elders in their families, such as an aunt was taboo and could be misconstrued as the young girl wanting to become sexually active. They, together with their friends, did at times access the internet for information but it was agreed this information may not at all times be correct. These findings were similar to the findings reported by Mosavi et al., (2014:112), Srivastava et al., (2011:86) and Verma et al., (2014:23) which stated that adolescent females in conservative societies such as Iran and India also did not have the luxury of freely accessing reproductive and sexual health information due to societal and cultural restrictions whereas their western counterparts in America had no such restrictions.

5.3.3 Attitudes towards people living with HIV and AIDS

It was interesting to note that despite participants not having any personal experiences with people living with HIV and AIDS most participants had positive attitudes towards people living with HIV and AIDS as they were knowledgeable about HIV infections. These findings were similar to that by Abrahams and Jewkes (2012:4) that reported that participants with knowledge of HIV were more likely to have a positive attitude toward people living with HIV and AIDS.

Negative attitudes from participants pertained to women who were HIV positive due to sexual promiscuity. Similar findings were reported in the study by Abrahams and Jewkes (2012: 5) which reported that females were morally judged for being HIV positive.

One participant was a student nurse with a high level of HIV knowledge; due to her professional experience with and knowledge of HIV positive patients she had a positive attitude toward patients. Studies by Dharmalingum et al., (2015:5) and Fomoroti et al., (2013:7) reported that nurses with no knowledge gaps rendered effective care to patients with HIV infections than those with knowledge gaps.

5.4 LIMITATIONS OF THE STUDY

The study provided a broader understanding and insight into the perceptions of young Indian adolescents in Chatsworth, towards HIV and AIDS. However the researcher did experience certain limitations. As originally proposed, the age group of participants was supposed to be young adolescents younger than 18 years of age. However, parents were hesitant to allow their children to be interviewed without them being present. The presence of the parents could have biased the outcome of the study as the participants would not be honest in their responses out of fear of parental reactions. Parental reticence could be due to the fact that the subject under study as it is a taboo subject in the Indian community. After discussions it was decided between the researcher and supervisor to interview participants 18-19 years of age.

The second limitation was that participants were hesitant to participate when they were informed about the subject under study due to embarrassment as these participants were known to the researcher. Snowball sampling had to then be used as the referrals would not be known to the researcher but was still from within the Chatsworth area.

5.5 RECOMMENDATIONS OF THE STUDY

The researcher has identified various challenges from the interpretation of the study findings. The researcher therefore recommends the following to bridge the gaps identified:

- The Life Orientation module taught at high school level should be reviewed to include information pertaining to AIDS and ARVs.
- Community involvement projects should focus on schools instead of within the community as participants stated that they were reticent to attend HIV and AIDS programmes held within the community due to fear of social stigmatisation.
- HIV and AIDS programmes offered at tertiary education facilities should be reviewed to include new and updated information relevant to the age of students on campus.

- HIV and AIDS programme facilitators should receive training on how to facilitate these programmes

5.6 CONCLUSION

The purpose of the study was to gain understanding on how young Indian adolescents in the Chatsworth community perceived HIV and AIDS in order to develop contextual relevant recommendations regarding strategies for addressing Indian adolescents on HIV and AIDS issues. The study concluded that the participants had more positive and correct perceptions than negative and incorrect perceptions about HIV and AIDS. It was noted however that risk perception amongst female participants was very low. Based on the conclusions and recommendations the study objectives were achieved.

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ANNEXURE A
ETHICAL CLEARANCE



UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/477/2015

Date: 25 November 2015

Student No: 4087-235-1

Project Title: Perceptions of young Indian adolescents in Chatsworth, towards HIV and AIDS.

Researcher: Dhanasagree Govender

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Prof AH Mavhandu-Mudzusi

Qualification: D Litt et Phil

Joint Supervisor: -

DECISION OF COMMITTEE

Approved



Conditionally Approved



Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

INFORMATION TO PARTICIPANTS

215 Silverglen Drive

Chatsworth

4092

Dear Participant

Re: Requesting permission to participate in a research study

I am currently registered for a Master of Arts in Nursing Science with the University of South Africa (UNISA) and have to complete a dissertation as part of the requirements for the programme. The title of my intended study is as follows:

“Perceptions of young Indian adults in Chatsworth, towards HIV and AIDS”

What is the study about?

I am interested in finding out more about what you know about HIV and AIDS; how it is spread, who gets HIV and AIDS, how can we prevent the spread of HIV and AIDS.

Permission to participate

As you are over 18 years, I would like to ask permission from you to participate in this study. I would also like to ask your permission to record our conversations. You would be expected to talk to me not more than two times for about 30 minutes each.

Voluntary participation

Please understand that you can choose to be involved in this study. The choice is yours alone. If you choose not to participate in this study you will not be affected in any way. If you do agree to be involved, you are free to stop participating at any time during the activities and tell me that you don't want to go on with it.

Your privacy

I will not be recording your name and details during our conversations, you will not be identified by name in our report, and I will make every effort to keep what you say private. The notes and recordings from the discussion with you will be stored in a locked cabinet in my office to which only I have access. However I may have to make it available to my supervisor at UNISA if necessary. A pseudonym (made up name) will be used. You can choose the name of your favourite television character. However if the name has already been chosen by another participant you will have to choose another character's name.

Risks and benefits

While I believe that there will be no negative risks to participating in this study, neither will there be any direct benefit to you. However the information that you share with me will most likely be of benefit to improving HIV and AIDS knowledge among you and your peers (individuals of your age group).

Questions, complaints or concerns

If you have any questions about the study, please contact me at any of the following numbers:

Office: 031 2041353 (07:00 – 16:00)

Home: 031 4038072 (after 17:00)

Cell phone: 084 5036454

ANNEXURE C

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Consent form

I agree to participate in the study. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop being involved at any point if I want to, and that this decision will not in any way affect me in a negative way.

I understand that this is a research project that will not benefit me personally.

I have received the telephone number of the researcher to contact should I need to speak about any issues that may come up while I am involved in the activities of this study.

.....
Signature of participant

.....
Date

.....
Signature of witness

.....
Date

I give permission for the discussions to be electronically recorded.

.....
Signature of participant

.....
Date

.....
Signature of witness

.....
Date

Consent forms will be made available in English only.

ANNEXURE D INTERVIEW GUIDE

Introductory statement

I want to thank you for participating in this research study. I would like to know your thoughts about HIV and AIDS. If at any time during the interview you would like to stop please let me know.

The researcher will initiate the conversation with general questions regarding:

SECTION A: ESTABLISH RAPPORT

I would like to ask you some questions about your background, your education, some experiences you have had, and some of your hobbies and interests in order to learn more about you

How old are you?

For how long have you been staying in Chatsworth?

What are you currently doing in relation to your studies?

How many are you at home?

What is your hobby?

The aim of the above questions is to build rapport and also to ensure that the participant is at ease.

SECTION B: QUESTIONS REGARDING KNOWLEDGE OF HIV AND AIDS

1. Kindly tell me your perceptions regarding HIV and AIDS.

(This will be the main question. If there is any gaps in the information provided the following questions will be asked to get clarity)

2. When you hear the words 'HIV and AIDS', what comes into your mind?

3. How do you as an Indian adolescence perceive a person who is living with HIV?

4. What do you understand about HIV and AIDS?

5. Kindly share with me the factors which contribute to the spread of HIV among Indian adolescence?

6. May you kindly share with me the steps which may be put in place to ensure the prevention of HIV among Indian adolescence?

Closing

It has been a pleasure talking with you. Let me briefly summarise the information that I have written during the interview. I will listen to the recorded information and get back to you if I need any further information. Is that okay?

Thank you very much.